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ABSTRACT

In September 1983, the Governor of Illinois requested that the Illinois Commission on Children examine community-based service systems as a partial means of delivering human services for children and youth. In response, the commission formed the Community-Based Children's Services Task Force to assist in improving the ways state agencies channel funds to local agencies. Letters were sent to persons responsible for child welfare, health services, and juvenile services in each state requesting information about the state's use of local agencies. This document provides states' responses to the task force's request for information; all but four states provided information, though replies from a few states were very brief. Extensive summaries from over 40 states describe organizational structures, program emphases, responsibilities, objectives, procedures, and/or legislative mandates. Lists of information sources conclude the document. Information about Illinois' community-based service system, not included in this document, is expected to be presented to the state legislature in March 1985. (RH)

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A SUMMARY OF HOW STATES USE LOCAL AGENCIES TO PROVIDE SERVICES FOR CHILDREN AND YOUTH

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A SUMMARY OF HOW STATES USE LOCAL AGENCIES TO PROVIDE SERVICES FOR CHILDREN AND YOUTH

Prepared by Ms. Dawn Murphy, Children's Consultant

The Honorable James R. Thompson, Governor, requested the Illinois Commission on Children to examine community-based service systems as a partial means of delivering human services for children and youth in Illinois. We accepted the task and formed a Community-Based Children's Services Task Force to assist us in creating a better way for state agencies to channel funds to local agencies and more effectively serve children and youth. The Commission suggested exploring other states' usage of local agencies, so letters were mailed to three state service areas--child welfare, health and juvenile services--in each state. This document reflects the information gathered. The list of those who supplied this information is on page 43.

Mrs. Helen Weigle, former Chairperson of the Commission, is the Chairperson of the Task Force. Ms. Donna Simonson, Executive Director, Ms. Dawn Murphy and Mr. Philip Schutte, Children's Consultants are providing technical assistance for the Task Force.

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ALABAMA

**Child welfare services are supervised by the state Department of Pension and Security and administered by local Departments of Pension and Security in each of Alabama's 67 counties. The Bureau of Family and Children's Services is responsible for developing policies related to adoption, foster care, protective services, day care, licensing, child care institutions, child placing agencies and group homes. As for usage of local agencies, the Bureau has 28 group homes and 24 child care institutions serving more than 1,000 children. Due to an increase in the number of children coming to the Department's attention who have acting out behavior and marked emotional disturbances, Title XX funds have been used in the past few years to contract with providers who are willing to serve this group of children. The Bureau has 10 residential facilities providing care for the child with marked emotional disturbances and 3 facilities providing care for the child with acting out behavior.

The Department provides a service fee of $50 to foster parents who provide care for children with special needs such as mental retardation, pronounced behavior problems, emotionally disturbed and physically handicapped. Homemaker services and parenting education classes, available in some counties, prevent foster care placements and enable children to return to their own homes.

The Department has recently formed a Division of Community Resources to plan, implement and coordinate a system to obtain and sustain maximum development of community involvement and utilization of resources such as: volunteers advisory councils; advocacy groups; local, regional and statewide agencies and organizations; the corporate, private nonprofit and religious sectors; and clients. The division has compiled information which describes preventive community projects statewide for children and youth.

**The Department of Public Health furnishes most of the personnel, supplies, and finances (state and federal funds) to the county Department of Health. The Department has two programs offering routine pediatric care available at local health departments. One of the two, the Well Child Program, is conducted in 63 of the 67 counties in the state. Services provided in these clinics include a physical and developmental examination, social and nutritional assessments, medical history, immunizations, screening procedures, patient and parent education and counseling and appropriate referrals. Nursing followup of children with Phenylketonuria (PKU) and those with hypothyroidism is accomplished through these clinics as well as the provision of Lofenalac and Phenyl-Free formula for PKU children. In the health department, preventive care for older children is mainly provided through the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program. The EPSDT Program, available in all county health departments, offers services to Medicaid eligible children up to the age of 21 years. EPSDT allows two visits in the first year of life and one visit per year for ages two years to 21 years.

Another special program within the health department which has had a great impact on the health status of children is the Immunization Program. The foci of the program are "to raise the immunization status of Alabama's children above the disease supporting levels of immunity for diphtheria, tetanus, pertussus, polio, measles, rubella, and mumps; to continually assess and maintain those levels; and to further refine an active surveillance system which is sensitive to any occurrence of these vaccine-preventable diseases." To this end, the Immunization Program provides vaccine to all 67 county health departments, and 11 satellite clinics, and 36 Primary Care Centers. The program provides vaccine to any of the 4,282 private physicians who request it. Funding for the Immunization Program is provided through both state and federal sources.

One major barrier to health care is the lack of transportation that exists in many areas of the state. Barriers also exist because of the pediatric programs' funding. The vast majority of pediatric public health is federally funded. Since 1981, the State of Alabama has experienced cuts in funding levels for child health. Well child clinics have decreased their target population to children 2 years of age and below. Even with this tightening of the target population, these

clinics, when working to capacity, will probably only see 28 percent of the in-need population. Although EPSDT clinics are offered in all counties, children who are not Medicaid-eligible cannot be seen in these clinics.

**The Department of Youth provides services to delinquent youths. It operates 3 institutions, one diagnostic and evaluation center, four group homes, and one wilderness program. The four community-based group homes provide food, clothing, supervision, housing, as well as counseling services. The group homes coordinate academic and/or vocational education within the community, as well as on-the-job training.

The group homes are as follows: 1) Bell Road Group Home in Montgomery has a capacity of 10 boys and served a total of 41 in 1983; 2) Gadsden Group Home also has a capacity of 10 boys and served 37 in 1983; 3) Mobile Residential Care Facility has a capacity of 15 boys and served 53 in 1983; and, 4) Troy State University Group Home, which has recently been changed to house 10 females. Last calendar year, the Troy Group Home served 32 boys.

**The Department of Mental Health is responsible for providing services to mentally retarded children. The Department funds four small group facilities for emotionally disturbed children and has Regional Community Health Services. One Child Placing Agency has expanded its services to provide respite care for the mentally and physically handicapped to prevent placement in institutions.

ALASKA

**The Department of Health and Social Services is responsible for administering most of the services to children. The only exception is the city of Anchorage which has a locally operated social service department assisted by native corporations. The Division of Family and Youth Services provides adoption, foster care, protective services, homemakers and day care. The Division also purchases a range of human services from nonprofit corporations, with six regional offices supervising 33 field offices, and these services have proven to be an essential adjunct to the direct services provided by social work and probation staff.

There are three major mechanisms for channelling funds to these agencies:

1. Competitive contracts/grants utilizing a Request for Proposal approach. Examples include:

   a. Preventive Youth Services Grant Program: A $2 million State funded grant program used to purchase community-based services which address both personal and family problems which, if unattended, may result in child abuse, neglect or delinquent behavior and may require direct intervention by the State. Services improve family competency prior to a breakdown in interpersonal relationships, intervene at an early point in times of stressful crisis situations, and/or achieve changes in maladaptive coping patterns which could result in a recurrence of abuse and neglect, and delinquent behavior.

   b. Juvenile Justice Delinquency Prevention Programs: A $225,000 federally funded Formula Grant Program (JJDP Act). Community-Based programs addressing various facets of the problem of juvenile delinquency are funded (e.g., restitution/community work projects, rural services models).

   c. Foster Care Support Services: The State has awarded contracts in Anchorage, Fairbanks and Juneau designed to increase the cooperation and mutual trust between foster parents and divisional case workers in order to improve the effectiveness and efficiency of the relationship. Specific benefits hoped to be realized include decreases in the turnover rates of foster parents, decreases in multiple placements of foster children, and increase "job satisfaction," on the part of the foster parents.

d. Homemaker Support: The State purchases adult and child protective homemaker support via a competitive RFP.

2. Legislative/NonCompetitive Grants

Funds appropriated by the Legislature to named recipients or designated agencies. These awards are normally the result of agency lobbying efforts; services must meet a public purpose and be provided on a nondiscriminatory basis.

3. Provider Agreements

Nonbinding agreements specifying a unit cost for services but not obligating the State to purchase a minimum level of service. Examples include child protection day care, adult foster care and residential care, and medical and psychological services.

ARIZONA

**The Department of Economic Security, Administration for Children, Youth and Families (DES/ACYF) is responsible for providing services to children, who are at risk of abuse, neglect or exploitation, and their families. Emphasis is placed on maintaining the child in the least restrictive setting, consistent with his/her needs and providing family based services to stabilize the family. Services are provided directly by Department employees and/or through purchase of service contracts with community agencies. The Department retains case management responsibility.

Contracted services include day support, counseling, parent aide services, parenting skills training and peer self-help groups (Parents Anonymous). The Department also contracts for foster home and day care home recruitment, study and training and volunteer coordinator services in some Districts. All services may not be available or purchased in all communities. Some services such as parent aide services and counseling are both purchase of service and direct service. This is dependent upon the availability of resources, cost of the service, budget constraints, utilization and need for the service.

Day support services have been developed to maintain children in the least restrictive setting (preferably their own home) and to prevent residential care. Day support services are used by both ACYF and the Juvenile Courts. These services are primarily for older children ages twelve (12) to eighteen (18). The services are provided on a less than twenty-four (24) hour per day basis. The service must include counseling and socialization and recreation. It may also include transportation and educational services such as tutoring, consumer education and sex education.

**The Department of Health Services has placed county health departments in the forefront by channelling federal and state dollars to the counties, because of the feeling that they are in the best position to further channel the funds to local private agencies. However, few, if any, of these dollars (MCH Block Grants and some state appropriations) do end up with private agencies through that system.

Arizona is the only state without a medicaid program and consequently it does not provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to low-income children.

**The Department of Corrections Juvenile Services Division contracts with a substantial number of private, non-profit community-based programs serving delinquent youth. For Fiscal Year 1983-84 the Division maintains contracts with sixteen residential treatment centers in the Phoenix area and six centers in the Tucson area. Presently, the Division has sufficient funding to place approximately 120 juvenile wards in such specialized programs.

The State Legislature appropriated close to $2 million for "purchase of care" to the Division for the 83-84 Fiscal Year. It is the responsibility of the Division to administer these funds where they are most effective, both from a treatment standpoint and from cost effectiveness considerations.

Juveniles are referred to particular programs based on identified treatment needs, population factors, and related concerns. Each private program has a maximum capacity which is loosely based on estimated projected use. Rates for each program are determined through contract negotiations involving the Division and the Arizona Department of Economic Security. All private residential programs in the State of Arizona must be licensed by the Department of Economic Security (DES Administration for Children, Youth, and Families).

In placing young people, the Juvenile Division utilizes a system entitled the "Placement Review Board." This two-member team reviews all prospective referrals for placement in order to effectively manage the increasing number of juveniles referred for community treatment and to ensure that referred juveniles are placed in the most appropriate program in a timely manner. Placement recommendations derive from institution treatment teams in conjunction with a juvenile's assigned Parole Officer (the Division incorporates a "continuous caseload" approach whereby Parole Officers play active roles both at the community level and institutional level).

Most of the private providers utilized are not limited to serving delinquent youth but also serve dependent, neglected, or (to a lesser extent) handicapped adolescents. Presently, there are five programs who either contract exclusively with our Division or focus their program on delinquent youths under State or County jurisdiction.

ARKANSAS

**The Division of Youth Services is responsible for youths aged eight (8) through eighteen (18) who are delinquents, juveniles in need of supervision (status offenders) and youth clearly at risk of entering the justice system if intervention is not provided.

Due to new legislation passed in 1977, the Division's resporsibilities increased to the following:

(a) Sponsor, encourage, and conduct research into the causes, nature and treatment of juvenile delinquency and the problems of youth; and serve as a central source of information and data collection regarding juvenile delinquency and the problems of youth in the State.

(b) Cooperate with, assist and solicit the cooperation and assistance of all public or private agencies or organizations involved in or dedicated to providing services to youth.

(c) Serve as a liaison between the state and local communities and the federal government with respect to youth programs and, subject to approval of the Director of Human Services and the Youth Services Board, enter into agreements with and make commitments on behalf of the state of Arkansas to meet requirements for obtaining federal assistance or grants for partially financing youth programs in the state.

The Division of Youth Services operates under general policy directions of the Arkansas Youth Services Board. This Board is composed of seven members appointed by the governor with the advice and consent of the Senate. Organizationally, the Division is one of eight divisions/offices comprising the Department of Human Services. The Division's Commissioner is hired jointly by the Board and the Director of the Department to administer the programs and services provided throughout the state by the Division.

Prior to the establishment of the Division of Youth Services in 1977, various state agencies were involved in the attempt to establish a network of community-based services for youth. Although

these efforts lacked adequate coordination, they provided the ground work for community-based programming in the state by funding various agencies who typically provided a single service to youth in a particular area of the state.

Reduction of federal and state funding for youth services and demonstrated need for a more comprehensive approach to service planning and programming provided impetus to the Division to reallocate available funds in order to ensure the statewide availability of designated basic services to the Division's mandated target population. The intent of the reallocation process was, therefore, twofold: to minimize the negative impact of reduced funding on service delivery and to include every county in Arkansas in a network of youth services programs that would include certain basic, required services.

The reallocation process occurred in 1981 and involved the following steps:

1. Identification of basic, required services: In order to establish a network of comprehensive programs, it was necessary to define what services together constitute a comprehensive program. The following services were identified: outreach (casework and reintegration), diagnostic (diagnosis and evaluation), treatment (psychosocial therapy), and one type of residential service (diagnosis and treatment, residential treatment, or specialized foster family care).

2. Identification of gaps in the current service system: An analysis of existing programs was completed in order to pinpoint counties where one or more of the basic services were not available and to identify areas where multiple programs existed. In areas where multiple programs existed there were typically a comprehensive type program and one or more single purpose programs offering only one service, serving only a single county, duplicating a service offered by the more comprehensive program, and/or providing a low priority service. It was concluded that by funding only one comprehensive program in those areas, administrative costs would be reduced and available funds would be more effectively spent on providing basic, required services to the entire area as a result of local planning responsibility for service needs being vested in one agency.

3. Reallocation of available funds: A funding level for each region was determined by a formula based on six demographic indicators of service need. These variables were: school dropouts; youth living with single parent; families below poverty level; youth unemployment; juvenile arrests; and total youth population.

   Data was collected on each variable by region. The region with the highest frequency for an individual variable was awarded 7 points, the second highest was awarded 6 points, and so on. Regions were ranked according to scores received on the six variables, and a percentage was obtained for each region's share of the available funding. Adjustments had to be made in some regions to ensure that the required services could be provided in all regions.

4. Establishing the network of comprehensive community-based programs: In order to identify the comprehensive community-based program with which the Division would contract for services in areas of multiple programs, a request for proposals (RFP) was issued in the following areas: Region I (Catchment Areas 1 and 2), Catchment Area 4 (Region III), and Region V (Catchment Areas 7 and 8). Selections were made on a competitive, objective basis.

The development of the comprehensive community-based youth services system was possible through the cooperative efforts of the Arkansas Youth Services Providers Association, the Division, and local agencies that participated in RFP processes. The end result has been

improvement in the quantity and quality of services available to delinquent youth, status offenders, and youth at risk and more effective utilization of reduced resources. The current communty-based service network is based on already established regions and catchment areas.

CALIFORNIA

**The Department of Social Services, supervises children's and family services, and handles child protection, foster care, adoption, and others which, in turn, are operated by the 58 county departments of welfare, social services, or human services.

California enacted two statutes in 1982 designed to provide community-based child abuse prevention services. Chapter 1398, Statutes of 1982 (AB 1733), established a ten million dollar child abuse and neglect prevention and intervention program. This program was intended to serve high risk children and their families who self-referred or were referred by other human services agencies, as well as those referred by public child welfare services. The services are provided by public and private community-based programs and are designed to augment existing public child welfare services by extending service to the high risk population and providing additional preplacement preventive services. The Department supports this program concept and the problems encountered to date are those that are inherent in establishing any new service delivery system.

Chapter 1399, Statues of 1982 (AB 2994), established California's state and county children's trust funds through a surcharge on certified copies of birth certificates. The county funds are to be used for child abuse and neglect prevention and intervention programs operated by private non-profit organizations. The state fund is to be used for innovative child abuse and neglect prevention and intervention programs, or evaluation and research or dissemination of information concerning existing program models. Chapter 1082, Statutes of 1983 (AB 607), added an additional funding mechanism for the state fund. Provisions of this bill allow taxpayers to designate on their personal income tax return that full dollar amounts in excess of their tax liability shall be contributed to the State Children's Trust Fund. These programs are still in the implementation phase.

**The Department of Health Services administers programs that are aimed at low-income families. It channels state funds to community-based agencies in the following ways:

1. Medicaid Funds

   In California, the Medicaid program is called Medi-Cal. Funds for Medi-Cal are channeled to community-based agencies through two methods:
   a. fee-for-service
      In California, the Medi-Cal program remains for most providers, with the exception of hospitals, a fee-for-service program. Community-based agencies are given a Medi-Cal provider number and bill the fiscal intermediary for services provided by the agency to Medi-Cal patients.
   b. prepaid health plan
      Community-based agencies have the option of applying for status as a prepaid health plan (HMP) in which they contract to serve Medi-Cal patients on a capitation basis.

2. Child Health and Disability Prevention Program(CHDP)/Early and Periodic Screening, Diagnosis and Treatment(EPSDT)

   California's EPSDT program is part of the CHDP program. EPSDT serves Medi-Cal children from birth to 21 years of age. In addition low income children with family incomes below 200% AFDC may receive examinations reimbursed by CHDP in two situations:
   a. one comprehensive screening examination for school entry, anytime from age 3½ years through 90 days after entrance into first grade or;
   b. well baby screening examinations for infants weighing 2500 gm or less at birth

All services are reimbursed on a fee-for-service basis. Community-based agencies are eligible to be providers.

3. Contracts for Health Care Services

There are a wide variety of programs within California's Department of Health Services which contract with community-based organizations to provide health care services. They include:

a. Rural Health Division
   (1) Farm Workers
   (2) Indian Health
   (3) Rural Health
   (Ambulatory health services for farm workers, Indians, and populations in the rural areas of the State)

b. Office of Family Planning
   (contraceptive, sterilization, and information and education projects)

c. Primary Care Clinics Projects
   (community clinics to provide ambulatory health services)

d. Maternal and Child Health
   (1) WIC
   (2) Perinatal care services
   (community-based agencies may receive contracts to provide services to women and children with incomes below 200% of the Federal poverty guidelines)

e. Health Protection Division
   There are two programs which contract with nonprofit community agencies. They are the hypertension and risk reduction programs.

4. County Contracts

In a number of areas in California, counties contract with nonprofit agencies to provide health care services for indigent patients. This is particularly true for the medically indigent adult program in which funds are allocated by the states to counties to provide health care services to indigent adults who are ineligible for the Medi-Cal program.

5. Population Served

Community-based agencies began in California when county public health departments were no longer able to assume the role in some areas of the State for caring for low-income residents. While the Medi-Cal program was to solve the health care problem for the poor, in reality, it did not. Many private providers refused to accept Medi-Cal clients and other patients were ineligible for Medi-Cal by reason of citizenship or having incomes just over Medi-Cal eligibility limits. Non-profit agencies such as community and free clinics arose to fill a need and continue to do so. The target population has remained the low income, often minority population generally living in less affluent urban areas or rural areas in which access to care is limited.

While there often is competition for funding between county health departments and nonprofit agencies and sometimes downright hostility, alliances have developed in many areas with sharing of resources and patients. The non-profit agencies are an integral and important part of the health care delivery system in California.

**The Department of Youth Authority: California has a tradition of state-county cost sharing for certain justice programs dating back as far as 1945. Based on a philosophy that crime is largely a local problem, and one best dealt with at the county level, the state has since then used several subventions or substitutes to encourage counties to keep offenders "at home" and to work with them there rather than sending them to state operated institutions.

The County Justice System Subvention Program is not a difficult program to implement: To participate, counties must 1) appoint a 16-person County Justice System Advisory Group, 2) not exceed their limit of adults and juveniles committed to state institutions, and 3) utilize one of two methods for determining the amount of state funds to which they are entitled. The Department of the Youth Authority is responsible for administering the program and is annually appropriated a fixed amount of funds. These funds are allocated to participating counties, usually on a per capita basis. Exactly how the funds are used is largely a matter of local discretion; more specifically, it is determined by each county's Board of Supervisors--a group which, in turn, accepts advice concerning funding priorities from the County Justice System Advisory Group. However, the county's intended use of funds must entail any activity connected/related to the local justice system. They must also be adequately described application for funds--submitted to the Department of Youth Authority each April 15--for the following fiscal year. The Department reviews these applications to ensure that use of funds meets the intent of the seven program categories (see below). If this requirements is met, the Department authorizes quarterly payments of funds to the counties.

In July, 1983, SB 789 made additional changes in the County Justice System Subvention Program which would improve the funding process and local programs for youth. The new bill requires the following:

1. Maintain/improve local justice systems.
2. Reduce number of juveniles in justice system.
3. Encourage selectivity in type of offenders retained locally.
4. Reduce recidivism at local level.
5. Reduce justice system administrative costs.
6. Provide maximum flexibility in local service delivery.
7. Enhance justice system planning and coordination.

This model aims at particular California needs, although other uses of such a model could serve other categorical spending needs. (Less than 10% of these funds are spent by community-based agencies.) A main theme of this subvention system is state channelling of money but local assessment of need/local spending decisions.

**Department of Mental Health: In California, the great extent to which counties are responsible for treating the mentally ill is reflected in the low rate of state hospital use and in the high percentage of state mental health dollars allocated to community mental health programs. In a state with a population of 24 million, there are fewer than 4,000 civilly committed mental patients in state hospitals, and 80 percent of the $600 million mental health services budget is spent in local mental health programs administered by the counties.

Each California county is required to have a mental health plan defining the services offered, costs, and the means of delivery. Responsibility for carrying out the plan is vested in the county mental health director, who is appointed by and responsible to the local governing body, the county board of supervisors. Thus, the state cannot directly influence the hiring or firing of a county mental health director.

The local mental health plan is developed with the cooperation of a mental health advisory board. There is usually a three-year plan, with a yearly update. The plan and the accompanying budget are reviewed and approved by DMH. The plan and the budget must also include an estimate for use of state hospitals during the coming year. County budgets are aggregated to arrive at the overall state budget. When the legislature passes its final budget, the counties are notified of the spending level for their mental health programs over the next fiscal year. This allocation forms the basis of monthly county claims for state funds, computed according to units of service delivered. The state reimburses counties for 90 percent of the net costs of approved programs. Counties, in turn, have to pay 10 percent of the cost of using the state hospitals.

The delivery of mental health services in some counties is organized entirely through county-staffed programs. In other counties, services are provided through some combination of county-operated and contracted services, since mental health services can be and often are contracted out to proprietary groups.

County treatment programs include a range of direct treatment programs, as well as indirect and supportive services. Voluntary patients make up the bulk of the program caseload, but involuntary treatment is available when needed.

The process for initiating involuntary treatment starts with identifying a suspected mentally ill person who refuses voluntary referral and treatment. Such persons can be brought to the county evaluation facility by relatives, friends, or the police. If the person is found to be a danger to himself, a danger to others, or gravely disabled as a result of mental illness, then he may be held for seventy-two hours of treatment. Another fourteen-day period of involuntary treatment may also be initiated by the treatment facility. At this point, the patient can request a court hearing for release on a writ of habeus corpus. Long-term involuntary treatment is possible under the terms of a conservatorship, which is established by a court hearing.

At any point during the initial seventeen days of involuntary treatment, a patient can request a change of status and accept voluntary treatment. In practice, the great majority of involuntary patients (87 percent) do convert to voluntary status before the end of the seventeen-day period.

Patients cannot go to a California state hospital on either a voluntary or an involuntary basis without the specific approval of the county mental health director. Patients discharged from a state hospital must have an after-care plan, which is developed by county mental health personnel. The discharge is not effected until the county is ready to accept responsibility for continued treatment of the patient.

COLORADO

**The Department of Social Services/Division of Family and Children's Services supervises 63 county-operated departments of social services for children and youth. The special services for children section functions from the state level and provides adoptions, foster care, protective services, day care, and residential care.

**Department of Health/Division of Family Health Services is responsible for administering maternal and child health programs, family planning and programs for handicapped children. At the county level, there are 14 organized health departments servicing 16 counties and public health nurses serve the remaining 41 counties. Maternal and Child Health Funds are allocated throughout the state. The Department specifies types of services for which funds may be used. Through this process, the Department has given preference to continuation projects and to local departments of health. This does not rule out the possibility of not-for-profit agencies providing services as long as they can meet criteria and challenge for funds through the application process. The Department has several not-for-profit agencies who are contractors under this process.

About 23% of the Department's contractors that use Title V Maternal Child Health Block Funds are not-for-profit organizations. These grantees do not, however, receive 23% of the funds available. It should be noted that many of the Department's programs, such as their Handicapped Children's Program, use a variety of vendors including not-for-profit entities in providing the services to children.

The Department of Health has utilized not-for-profit groups to provide service where it has not been available through a more publicly funded agency, including local health departments, public hospitals and so forth.

The Department of Health has used non-profit agencies for contracting in other of their family health services programs, including the Family Planning Program, the WIC Program (Women, Infant and Children's Food Supplement Program), and the Migrant Health Program. Overall, there is not a single advantage to using a not-for-profit over a public agency, and the Department has tended to look at agencies with respect to their ability to deliver the needed service. One possible advantage of using public agencies over not-for-profit agencies, is that public agencies are required to have a careful audit and audit requirements for not-for-profit agencies are not generally so rigorous. With a small administrative staff, it is difficult to manage careful financial tracking of a large number of not-for-profit agencies.

**The Division of Youth has a Juvenile Diversion Program which uses the offense-based criteria to determine a youth's eligibility for the diversion. It recommends that youth with less serious offense histories be lectured and released, and youth with no police involvement be left alone. The intent is to avoid negative labelling, widening the net, and cost inefficiencies. The Juvenile Diversion Program is to provide community-based alternatives to the formal court system that will reduce juvenile crime and recidivism, change juvenile offenders' behavior and attitudes, and reduce the costs within the juvenile justice system. In order to effectuate the program, the division contracts with governmental units and non-governmental agencies (private non-profit agencies, corporations, and associations) to provide services for youth. For local agencies to receive funds, their program must demonstrate the following:

(a) Meet a demonstrated community need as shown by a survey of the type of community, its special circumstances, and the type and number of youth who will be served by the project;

(b) Provide services that do not duplicate services already provided in the community;

(c) Show community support of the project through receipt of nonstate funds or in-kind supplies or services to meet at least twenty-five percent of the total cost of the project.

CONNECTICUT

**The Department of Children and Youth Services is mandated to plan, create, develop, operate or arrange for, administer and evaluate a comprehensive and integrated statewide program of services, including preventive services, for children and youth who are mentally ill, emotionally disturbed, delinquent, abused, and neglected including all children and youth who are or may be committed to it by any court, and all children and youth voluntarily admitted to the department for services of any kind.

One of the premises the department operates on is to provide a comprehensive and integrated system of services for children, youth and their families through a combination of state and local, public and private resources. The Division of Community and Preventive Services, created in 1977, develops community-based prevention services for children and youth. The staff goals are to encourage municipalities and private organizations to establish community facilities and programs, to support parenting education and to promote consultation programs for teachers.

Millions of dollars in grants-in-aid from DCYS help support 22 privately-owned and operated child guidance clinics, seven extended day treatment programs, the Parent-Child Resource Centers and 54 municipally-based youth service bureaus serving 70 cities and towns. The state is divided into 5 regions, each one has a regional networker/planner, who assesses the needs of the community.

DELAWARE

**The Division of Public Health through the Maternal and Child Health and Crippled Children's Services Programs provides or pays for services for children and youth in Delaware. In the latter category, the Division's Speech and Hearing Program contracts with the Wilmington Medical Center for audiologic and otologic clinic services for children in New Castle County while providing direct services to children in Kent and Sussex Counties. The Division also contracts with Wilmington Medical Center for outpatient services for children with cystic fibrosis. The medical center operates the only clinic for cystic fibrosis in Delaware. As part of the MCH Block Grant, the Department is in their second year of funding the Delaware Adolescent Program., Inc., which provides comprehensive services to pregnant teenagers and their families throughout the state. Finally, under the Delaware Family Planning Project funded in part by Title X, the Division contracts with Delaware League for Planned Parenthood for family planning services for approximately 10,000 patients in northern New Castle County.

DISTRICT OF COLUMBIA

No information was received.

FLORIDA

**All services for children and youth are under the Department of Health and Rehabilitative Services.

Delinquency Services: When a child gets into trouble by breaking the law, HRS intake counselors receive the complaint, look at the problem and recommend to the state's attorney what action is best for the child and the community. The state's attorney then decides whether or not the case will go to court. Florida law provides that under certain conditions, a child may be held in detention while awaiting a court hearing. If an intake counselor places a child in detention, a detention hearing will be held before a judge within 24 hours.

In some cases, the state's attorney will not require the child and family to go to court, but will assign the child to work with a HRS counselor or a local service agency. Through counseling and certain work assignments, the child will be helped to understand the consequences of his or her behavior and will be assisted in learning how to get along in the community without breaking the law. A variety of delinquency prevention and diversion programs are available to help keep children from going to court and to prevent them from getting into further trouble. Involving a child in such programs without his or her having to go to court can only be done with the approval of the state's attorney's office.

If a child does have to go to court, the judge may order that he or she be placed on "community control." This means that the child will be supervised by a counselor for a period of time. The child may be required to perform community service and/or make restitution to the victim. Sometimes as part of the community control plan, the child may attend a nonresidential treatment program such as a TRY center or Marine Institute or receive intensive counseling for more specialized supervision and activities.

If the judge decides that community control is not appropriate and that more intensive treatment is needed, the child may be committed to the custody of the department and placed in a treatment program for committed children.

There are many types of commitment programs including short-term residential programs such as STOP camps and Project STEP that use wilderness settings to teach self-discipline and responsibility. Individual and small family group homes are programs contracted by the

department to provide a stable home-type environment. More restrictive programs include halfway houses, START centers, group treatment homes and training schools. Each of these programs has a different way of helping a child who is finding it difficult to behave in a responsible manner.

Upon completion of a commitment program, a child may be returned to the community on "furlough" status. While the child is on furlough, he or she will be counseled by a community control counselor, who will prepare him or her for final release from HRS and court authority.

Mental Health Services: Community mental health services provide many programs for children with emotional problems. These programs include day treatment for pre-schoolers and school age children, diagnostic and evaluation services, short-term residential treatment and counseling services for very young parents. These services are designed to allow children to remain at home whenever possible. For children who have more serious emotional problems and must be removed from their homes, residential treatment is available. These programs include therapeutic group and foster homes, Eckerd Wilderness Camp programs and psychiatric treatment centers.

Specialized Family Services: The Specialized Family Services program helps families solve a variety of problems. Sometimes the problems are of an emergency nature such as being out of food, having the utilities cut off or having no place to live. Many of the problems are due only to lack of money while others are related to health care, transportation, employment and other needs.

This program can provide direct assistance in many areas including consumer education and protection, employment services, escort services, health support services, home management services, housing improvement services and transportation. Other services such as child day care and legal counsel must be provided by making arrangements with or referrals to agencies and providers in the community.

GEORGIA

**The Department of Human Resources houses all services for children and youth and supervises the programs at the state level.

Under the Division of Family and Children Services, programs are administered in Georgia's 159 counties by local Departments of Family and Children Services. Services include adoption, foster care, protective services, day care, homemakers, family planning, medicaid, AFDC. In 1983, the Commissioner created an Office of Children and Youth to plan and coordinate programs for young people across divisions within the Department. This is still in the beginning stage.

**The Division of Public Health's activity in community-based services regarding children and youth is principally limited to the Division's involvement with the Jobs Bill/Maternal and Child Health Project which provides contracts to 29 not-for-profit agencies in the area of Community Health Outreach for Consumer Projects and Teenager Peer Counseling Pregnancy Prevention Projects. Additionally, in 1981, over 27,000 of Georgia's teenagers became pregnant and almost 800 of these pregnancies occurred in children age 14 and under.

The overall thrust of the Georgia Department of Human Resources is to involve more of the community-based agencies in the delivery of health care with a special interest on a Healthier Generation of Georgians by primary prevention of physical and mental disabilities; early intervention and treatment; child development and youth rehabilitation among the 230,000 troubled children who need the help of more than one agency.

**The Division of Youth Services operates 17 regional youth development centers providing temporary secure detention for adjudicated delinquents and alleged juvenile offenders. The Division also contracts with private non-profit agencies to provide specialized services. They are:

1. Community-based agencies for preventative services in the area of juvenile delinquency:

   For over two years the Division of Youth Services has contracted with three family counseling therapists, certified by the American Association for Marriage and Family Therapy (AAMFT). For $40 an hour 6-8 staff attend 1½ hour family supervision sessions for 20 weeks. Staff receive training in the systems theory of family counseling. Families from their caseload are counseled by the trainer while the staff watch from behind a two-way mirror. The skills enable them to counsel families in crisis. Youth at intake, on probation, committed and on aftercare can be referred to the family counselor. At the present time the Divsion's statistics are showing that staff with family counseling skills are keeping youth in the community more successfully than staff without these skills.

2. Community-based agencies used as alternatives to incarceration for the juvenile delinquent and unruly children:

   a. The Division has a policy of keeping children at home and with their families . In cases where this is impossible, they contract with children's homes statewide to serve the youth. The average length of stay is six months to a year and the cost is $10.71 per day.

   b. For some children committed to the Department of Human Resources for delinquent and unruly acts and who can remain in their homes, there is Project Adventure. Project Adventure combines outdoor group building activities with tutoring programs in math, English and reading. The service is provided for $25 a day for six weeks for twelve youth. The advantage is that the school personnel are involved in the program and become advocates for the youth when they re-enter school.

   c. Wolfcreek Wilderness Program: Wolfcreek is for committed delinquents in lieu of placement in Youth Development Centers. For 30 days 10 youth and a counselor spend time in the woods building group identity and learning how to become a team member. Based on the "Outward Bound" concept, the goal is to help the delinquents transfer their experience in the woods to their role as good citizens in the community. The cost is $45 a day per youth.

   d. For the severely disturbed committed youth: The Department of Human Resources has an Inter-Divisional Troubled Children Committee which screens, reviews, and recommends to the Commissioner, those youth considered appropriate for placement in a private residential treatment facility. These would be children and adolescents who are socially/behaviorally/emotionally disturbed and need long-term, intensive residential programs. Some might also be mentally retarded although retardation alone would not be a sufficient criterion. Most will have been tried in a variety of other services - foster care, child care institutions, Youth Development Centers, mental hospitals - with clear evidence that such services are not sufficient to their needs. All youth approved for purchase of this care must have a recommendation from a psychiatrist or Ph.D. Clinical Psychologist that this is the most appropriate service. The three (3) programs used in Georgia are Anneewakee in Douglasville, Georgia; Devereux in Bartow County, Georgia; and Georgia Charlee, Inc., in Atlanta. The cost of care is higher for these children reaching to $73 per day.

HAWAII

**The Division of Mental Health, under the Department of Health developed community-based mental health services for children and youth. The islands are divided into eight catchment areas

and each of these is serviced by a community mental health center which comprises several satellite mental health clinics, a children's team, day treatment programs, consultation and education services, and specialized services to substance abusers, penal code patients, and the elderly. Approximately $10 million, or two-thirds of the State's mental health budget is channeled into the provision of community-based services. Each community program unit throughout the state has a citizens' advisory board which informs the division about community problems and whether services are relevant and effective. Since Hawaii is small, the State runs its own mental health centers instead of private agencies providing the services.

IDAHO

**No information was received.

INDIANA

**The Department of Public Welfare supervises Indiana's 92 counties which are the direct providers of social services--including income maintenance--to children and families. All counties over 100,000 population are required to have a Child Protection Service Unit. Counties also provide foster care, adoption, day care, services to run-aways and delinquent youth. The Indiana Title XX Social Services Block Grant Program provides funding for a variety of community-based services directed toward children and youth by contracting with both not-for-profit and for profit community-based agencies to provide services for Indiana residents who meet the need and income requirements. The agencies must submit proposals for the services which they plan to provide. The Title XX staff grant contracts based on the needs of each of 17 regions of the state. The contracts are monitored to assure the services provided meet program standards.

Indiana's Title XX Block Grant purchases several services directed toward the needs of children and youth. Following is a brief synopsis of these services: day camps, volunteer visits which match a youth with an adult role model, supervised recreation, adolescent alcohol and drug program, residential camping, supplementary tutoring and group youth development counseling for economically disadvantaged youth. There are also services available for the physically disabled and for the deaf. In addition, the Indiana Title XX Program administers funds for the Youth Services Bureaus whose primary functions are youth advocacy and delinquency prevention. Additional services for children and youth are purchased by the Indiana Title XX Program from Mental Health Centers through the Department of Mental Health, from the County Welfare Departments, and from the court system.

The Indiana Department of Public Welfare has recently begun planning for the expansion of Preplacement, Preventive and Reunification Services in the 92 counties by retaining the Child Welfare Worker. Each worker participates in an extensive continuum of a caseworker training module which emphasizes family dynamics and helping families use community services. The Department feels caseworkers are the best resources to use to help children and families receive a continuum of services.

IOWA

**The top priority of the Department of Health's, within the Division of Personal and Family Health, for four years (1979-1983) has been integration among programs. Efforts have been made for local staff of Maternal and Child Health Centers, Family Planning, and WIC to share resources. The most successful efforts have been between WIC and Maternal and Child Health programs who now share staff and have joint clinics.

The Iowa State Health Department currently has a formal agreement with the Department of Social Services who administers Title XIX of the Social Security Act. The Department also has a

formal agreement with the Child Health Speciality Clinics, Iowa's Crippled Children's Program. And the Department is negotiating an agreement with the Department of Public Instruction, Special Education Division to coordinate hearing screening activities.

In addition, the Department has coordinated with the Departments of Social Services and Public Instruction and the University of Iowa during the past two years to study the coordination of Maternal and Child Health Services. Two regions of the state have been selected to implement suggested coordination activities on a trial basis.

A Memorandum of Understanding has been developed with the Iowa Foundation for Medical Care.

The Iowa State Department of Health's Dental Health Program has jointly supported, with the University of Iowa College of Dentistry and the State Department of Public Instruction, Curriculum Development Division, the joint implementation of improved dental health education of the elementary level of the public schools.

The Maternal and Child Health Program has established and maintained a close relationship with the Pediatric and Obstetrical Departments of the University of Iowa College of Medicine, University Hospital School, School of Nursing, and Specialized Child Health Services. These units have assisted in developing in-service education for public health nurses and hospital staff as well as standards and guidelines for the delivery of services.

The private, nonprofit nursing services, such as the visiting nurse associations, county and city boards of health, county boards of supervisors, other state and local health planning organizations, assist in the necessary planning and development of maternal and child health centers, improved county hospital inpatient and outpatient services, Early Periodic Screening Diagnosis and Treatment (EPSDT) Programs, and local immunization programs.

Funds Allocation: Local boards of health and private nonprofit agencies prepare grant applications requesting MCH funds to either start or continue to provide maternal and child health services in their service areas. The applications are prepared using guidelines furnished by the state agency. The grant applications are reviewed by the MCH staff for feasibility and comprehensiveness of services.

A system of indicators is used to objectively fund projects based on need of service area and performance of the project. The indicators include percent of High Risk Births; percent of low birth weight births; per capita income; percent of funding provided by applicant fees or other sources; cost per encounter; and number of encounters per full-time equivalent staff. Each agency is rated on each indicator. The final scores are to help determine funding levels.

KANSAS

**In Kansas there is an absence of a statewide coordinated effort to use community-based services for children and youth. However, there are community-based agencies offering infant stimulation and training for the young child. Some of these are Title XX agencies and/or attached to the local education agency.

KENTUCKY

**No information was received.

LOUISIANA

**The Department of Health and Human Resources under the Division of Youth Services, provides probation and aftercare services for delinquent youth. The Division also contracts with private non-profit groups which provide some service in the areas of shelter care, residential placement and delinquency prevention. Shelter care and residential placement operate with state contracts based on a cost per day of care provided or maintained. The delinquency prevention contracts are at fixed levels of funding and generally provide for counseling, tutoring, recreation and cultural enrichment activities for youth identified as at risk due to some initial school, family or law enforcement problem

A program emphasizing the use of volunteers to assist clients or potential clients has just been initiated Department wide. The focus here has been to award grants to local groups to initiate or expand volunteer services available to clients. The Division believes this approach holds particular promise in terms of building a state/local partnership in meeting human needs. This recent effort also supports very well the agency's delinquency prevention program, which is entirely based upon community organization principles. No grant or contract funds are available; however, as part of this program. The Division relies entirely on local resources.

MAINE

**The Department of Human Services provides services to the residents of Maine in all 16 counties through five regional offices. The Bureau of Social Services provides child protective, foster care, day care, adoption, family planning and mental health services. Historically, the Department has been purchasing social services from community-based, non-profit agencies since the early 1970s. As the state's administrative agency for both federal and state Child Welfare and Title XX Social Service Funds, the Bureau of Social Services is the entity responsible for the purchase of services.

Over the last six years, the Department of Human Services has increased its commitment to targeting social services to the most vulnerable of its population with special emphasis on the children within that category.

The Bureau's Divisions of Child & Family Services, and Purchased & Support Services are responsible for identifying the full range of services needed by children who are or are at risk of being abused, neglected or exploited and children who are in the care or custody of the State. In addition, the Division of Purchased & Support Services along with a new Family Services program are responsible for planning services aimed at reducing the risks of abuse and neglect.

The planning process used encompasses the service needs that are available from and delivered by Department staff in its Regional Offices and additional services are not available through the Department or other State agencies. These additional services are then sought through private agencies in the geographic areas identified by the Department's Regional offices.

The Division of Purchased & Support Services is responsible for procuring these services. This Division also procures services for other target populations including: elderly persons who are at risk of institutionalization; mentally retarded persons living in the community; refugees; substance abusers; etc. Where possible, the Division procures specific services that have been identified as needed by multiple target populations through one contract per private agency. Under this procedure, levels of service to be purchased for each target population are delineated in the contract.

Because of the intensive needs of child protective and foster care clients, the Division procures specialized services such as emergency shelters, residential treatment, sexual abuse counseling, etc. in addition to multiple purpose services such as day care, homemakers, and transportation.

The Department of Human Services considers the services it purchases from private agencies at integral components of its direct service system. The quality and responsiveness of the services purchased continue to enhance the core services delivered by Department staff in improving the lives of Maine's children.

MARYLAND

**The Department of Health and Mental Hygiene, under the Division of Juvenile Services Administration, has adopted and advocates the development of a service delivery system that reflects a continuum of services from prevention through institutional and aftercare services. While the Division shares state-owned and operated programs, it also attempts to collaborate with the private sector for certain kinds of programs.

These collaborative efforts are funded in a variety of ways. Generally, the Division contracts or provides a grant award for the particular services. When contracting, and depending upon the scope of the service(s) to be provided, the Division has three options. They are: 1) Special Payments, 2) Per Child Contracts, and 3) Block Contracts. Special Payments is a method by which the Division hires a person(s) for a specific demonstration period. While these persons must meet the qualifications of a merit employee, they are not usually selected from a civil service list, are not considered to be eligible for any permanent employment within the State Merit System, and are employed only so long as funds are available for the specified purpose. After a time period of from one to two years, the Division must determine whether or not it wishes to request via the normal budgeting process making such a position or positions permanent. In such an event, the person so employed would be entitled to such fringe benefits as health insurance, which the "Special Payment Employee" is not. The uncertainty of this contractual arrangement is problematic for many persons and does not assure program stability.

Per Child Contracts are generally with a not-for-profit service provider and individuals who have agreed to some pre-determined rate for youth placed in their program. They are reimbursed for services provided on a per diem basis. Examples of these services are group homes, residential treatment programs, and a variety of clinical and supplemental education services.

Block Contracting is another way in which the Division contracts for community-based services. In this instance, the Division is funding 75% or more of the program. Here, the Division is not only determining the scope of the effort, but delineating some specific expectations and guidelines. Services for which the Division has contracted via this method are alternative school/counseling day programs, group homes, diagnostic and treatment projects and structured shelter care. Most often, the initial contractor is determined via a competitive bid process. A few have been selected on a sole source basis, where the service is unique or the identified provider is the only respondent to Request for Proposals. Continuation of the contract is tied to satisfactory performance and availability of funding.

Grant awards are made on a similar basis. That is, they are initially awarded following either a competitive bid or sole source process. An exception to this procedure is made when a local government or governmental agency is to administer the grant award. As in the block contracts, grant awards carry specific expectations or conditions to which the contractor is expected to adhere, and continuance or refunding is tied to satisfactory performance. Examples of services provided via this arrangement are runaway programs, youth services bureaus and structured shelter care programs. It might also be added that many of these programs, if not all, are required to obtain matching funds or in-kind services from other sources. This method is most often used for one time only efforts such as a particular time limited research study, except runaway programs, where federal funds are provided.

**The Division of Preventive Medicine Administration is under the Department of Health and Mental Hygiene. Its responsibilities include Maternal Health and Family Planning, Hereditary Disorders, Child and School Health, Dental Health, WIC, MCH Nutrition, Day Care Center

Licensing, Acute Communicable Diseases and Epidemiology, VD; Tuberculosis; AIDS; Refugee and Migrant Health, Immunizations.

Maryland is fortunate to have the State divided into 24 local units, each with local government and respective local health, education and social services agencies. Funding for local health services to children and youth is possible through the following main methods:

1. State/local matching formula to local Health Departments (i.e., well child and EPSDT services, maternity clinics, etc.)

2. Direct grants to local Health Departments, non-profit groups (i.e., WIC local agencies, Title X family planning, IPO grants, Adolescent Case Managers, etc.)

3. Assignment of State Merit System positions to local Health Departments (i.e., pediatrician, PNP, certified nurse-midwife clinicians)

4. RFP contractual-competitive proposals (i.e., IPO Grants)

In general, localities are encouraged to define likely target populations themselves, except where federal or other categorical criteria take precedence.

MASSACHUSETTS

**The Department of Social Services delivers services to children, families, and disabled adults. It operates through 6 regional offices which supervise the administration of programs and services provided through 40 Area Offices around the state. The office for children functions as an advocate and is responsible for foster care, mental health, residential care for adjudicated delinquents and provides children and youth services directly through their own employees or they purchase services from private agencies through contracts.

A state agency interested in purchasing services designs a "Request for Proposal" which describes the type of service they intend to purchase, population to be served, funding available and requirements of contracting agencies (purchasing standards). A timeline for making contracting decisions is usually included.

Once those decisions are made, the RFP is sent out to agencies who have expressed an interest in contracting for the service or are on a general mailing list. For new services, some state agencies send announcements of the RFP and funds to local newspapers, community groups and area newsletters.

Agencies interested in applying for funds are usually given approximately thirty days (this time period has been known to be reduced depending on administrative decisions, crises or other "pressure") in which to respond to the RFP.

An additional time period is delineated for review of the proposals by citizen groups (Councils and Area Boards) and agency staff who are involved in program and contracting areas. The optimal time period for citizen review is at least thirty days. This allows for a thorough review of materials, site visits and interviews without disruption in other volunteer activities. However, depending on a variety of factors (administrative decisions, commitment to citizen involvement, etc.) this time has also been shortened.

Once all recommendations are received, the state agency (appropriate staff) make the final decisions as to the awarding of contracts. Agencies are notified and those selected are then involved in negotiations which result in a contract with the state to provide a service. Contracts specify services, quantity, population served, expenditures, rate and procedures for reimbursement and other requirements relevant to delivering the service.

In addition to the state funding agency, the Rate Setting Commission (RSC), Administration and Finance (A&F) and the state Comptroller's Office are involved at certain levels regarding contracts. This involvement focuses on the fiscal aspects of the contracts (rate of reimbursement, allowable expenditures, state regulations, cost analysis, payment to providers). The state funding source is responsible for monitoring of the contract.

Private agencies, who are interested, respond to a particular "Request for Proposal" (RFP). Agencies document the need for the service, their ability to provide the services, previous experience and financial status. In addition, the proposal describes how the agency will provide the specific services being requested, goals and objectives of the service, agency background, existing programs/services and interaction with other community agencies/groups.

If selected, private agencies will then enter into contract negotiations with the state agency. As stated previously, agencies are reimbursed by the state after the services have been delivered. Therefore, contracting with the state requires documentation of service expenditures and completion of a variety of forms in order to receive reimbursement for services.

**The Department of Mental Health is in the process of eliminating state-administered programs and phasing in service contracts to private non-profit providers. This process, which began in 1979, is a gradual replacement of all Massachusetts state hospitals. This new system would be operated largely by the private non-profit sector, funded by a combination of government monies and third-party reimbursements, and organized into three levels, or tiers.

First tier: Community Mental Health Services. This tier is to consist of an expanded community service system for the vast majority of patients needing mental health treatment and rehabilitative services. Examples of these services included outpatient treatment, crisis intervention, case management, day treatment, social clubs, supervised vocational opportunities, and a continuum of supervised group homes and apartments.

Second tier: Community Hospitals and Intermediate Care Facilities for the Mentally Ill. While the large majority of mentally ill people in Massachusetts state hospitals could be treated in community programs of the kind described above, some obviously require a more intensive level of care in a more protective setting. Therefore, community hospitals should develop the capacity for treating all voluntary and involuntary patients (except for the most violent and difficult to manage) needing brief hospitalization. For patients who require this level of care for a more extended period of time, we proposed that intermediate care facilities for the mentally ill be established. These settings would be relatively small, as residential in character as possible, yet more protected and secure than the residential settings of the first tier.

Third tier: Specialized Back Up Services. For the minority of acute and long term patients who were too disturbed to be managed in either the first or second tiers, specialized intensive care units within selected high quality medical centers or university-affiliated private psychiatric hospitals have been established. These units are operated by those facilities in accordance with an explicit and strictly monitored contract with the state. They are well staffed with experienced personnel and coordinated with professional and paraprofessional training programs in order to attract the highest quality staff. Also, opportunities for research on the treatment of these difficult patients are continuing.

MICHIGAN

**Michigan's Office of Children and Youth Services was created by P.A. 1978, Act 87, as a single purpose entity within the Michigan Department of Social Services. The office is responsible for the planning, development, implementation and evaluation of children and youth services conducted, administered or purchased by the Department. With some exceptions, services to

Michigan children, youth and families are delivered directly by 83 local social service offices, under the supervision of the Department's Field Services Administration. Administrative support to OCYS (personnel, finance, data processing, etc.) is provided by other offices within the Department of Social Services.

Services to children, youth and families concentrate on the prevention, detection, control and correction of the problems of child abuse, neglect and delinquency. As of September 30, 1982, 15,092 children were in the care of the Department. The children served can be generally divided into three main groups:

1. Children temporarily or permanently in the care of the state per a court decision that they have been abused or neglected.
2. Children in the care of the state because of a court's finding that they have violated state law and should be supervised by the state as a result of their delinquent behavior.
3. Children whose parents' rights have been severed by court action and who are being placed for adoption.

Protective service is handled totally by the state. Foster care resources and casework services are purchased from the private sector. Michigan is presently analyzing the differences in children's foster care, length of stay between direct state department supervision and purchased supervision. The analysis will give differences in length of stay, compare costs between purchased and directly provided supervision, and propose any needed corrective actions. Private agencies also participate in Adoption Placement services. Out of the 1,000 adoption placements made in FY 81-82, 489 were made by the private agencies under contract with the Department.

One major purpose of the adoption purchase of service program has been to gain a contribution from the private sector in special need adoptions. When the purchase of service program started in 1976, the first year of operation resulted in private agencies placing 151 DSS children. That number was tripled in FY 80-81, four years after the program had commenced. In regard to those children placed who are "special need", the performance of purchase agencies has shifted somewhat from year to year. But overall, there have been increases in the proportion of black and handicapped (especially emotionally handicapped) children placed by private agencies.

The state contracts with private agencies to provide diversion programs, runaway services, and career opportunity programs.

A child care fund has been established where state and county share the cost of county services to neglected and delinquent children and youth. The major goals in the administration of the Fund are:

- to reduce the inappropriate use of institutions and other out-of-home placements;
- to establish a single foster care payment system that provides equal access and equal treatment to all children who are in need of placement;
- to ensure a statewide system of placement facilities and alternatives to placement that assures care, treatment and appropriate geographical proximity of services. Major activities in the administration of the fund include development of policy and program concepts for county implementation, maintaining a program of audit and policy control in cooperation with the Department of Treasury, the Auditor General and Social Service Internal Audit, and providing on-site program assistance to counties.

Originally the Fund provided financial assistance for out-of-home placement services. The result of this funding restriction was placement of children who may have not required it and, since out-of-home care is more costly, county and State Child Care Fund expenditures increased. In 1975 the legislature created an in-home care option that permitted reimbursement for the care of eligible children placed in their own home rather than in foster care.

The purpose of the in-home care option is:

- to provide for early intervention to treat, within the child's own home, problems of delinquency and neglect;
- to expedite a child's return to his or her home.

In order to accomplish this purpose OCYS:

- may expend up to 20% of state appropriations to the Child Care Fund as match for county Child Care Fund expenditures;
- may expend funds from other sources authorized in legislative appropriations for new or expanded programs.

An in-home care county proposal must be jointly developed by the juvenile court and the Department of Social Services and must indicate how each separately identified component of the proposal integrates with other services respectively provided by the court or the Department (including services directly provided or purchased).

**The Department of Public Health provides funding for maternal and child health services to local agencies. In almost all cases, the local agencies which receive funds are the local health departments (48 local government agencies serving all 83 counties in Michigan). Funding for not-for-profit private agencies is limited to a few demonstration projects awarded on a competitive application basis.

MINNESOTA

**The following information is a summary of Minnesota's Community Social Service Act, written by Gary Haselhohn, Assistant Commissioner of the Department of Public Welfare Social Service Bureau.

Two basic patterns of administration of public welfare programs among the states are usually spoken of as "state administered" and "state supervised -- locally administered". The unique characteristics of the latter are that the direct service personnel are employees of local government (usually counties), local tax levies finance a portion of the costs of income maintenance and social service programs, and local elected officials have some degree of authority to establish program policy. Such states are in the minority and the trend has been toward greater degrees of state administration.

However, the Minnesota State Legislature in 1979 enacted legislation, The Community Social Service Act, the major impact of which is to strengthen local administration of social services.

This is accomplished essentially by providing new authorities and responsibilities for local elected officials, i.e., county commissioners, to exercise in the planning, funding, providing, monitoring and evaluating of public social services. It is important to note here that community social services as defined in the Act include not only the services in the Comprehensive Annual Services Plan (Title XX), but also a variety of mental health services. The latter encompasses a broad array of community services to the mentally ill, mentally retarded, and chemically dependent; services which had previously been funded through an elaborate and complex state grant-in-aid system through which grants were provided to such service providers as Area Mental Health Boards, Development Achievement Centers and various drug and alcohol treatment resources. Also affected by the Act is a state grant-in-aid system for child care services authorized by state statute and funded by state appropriations. All of the specific grants-in-aid required some percentage of matching funds from local tax levies. So the Act not only strengthens the authority for local administration of the customary "public social services" but provides for integration of such services with those others identified above under a single governing board, the county board of commissioners.

Funding of Services: The Community Social Service Act impacts funding for services primarily through two separate formulas, one for the distribution of state appropriated monies and the second for the allocation of the state Title XX allotment to counties.

The state appropriated funds that had previously been earmarked for the grants-in-aid mentioned above and for local social service administrative costs are now distributed to counties in a single "block grant" by a formula which takes into account each individual county's income maintenance caseload, general population and population over 65 years of age. The county, in turn, must provide a tax levy at least equal to the amount of its block grant. Those two sources of funds can be spent by the county for the direct provision or purchase of those social services specified in the Act. For calendar years 1980 and 1981, maintenance of effort is required insofar as child care services and services to the mentally ill, mentally retarded and chemically dependent are concerned. After 1981, that requirement expires.

The State Title XX allotment is allocated to the counties through a second formula which takes into account the two factors of income maintenance caseload and general population. It should be emphasized that this is an allotment formula, i.e., it tells each county the amount of the state Title XX allotment it can earn through the usual methods of claiming 75% federal financial participation for the cost of those services included in the Comprehensive Annual Services Plan.

Local Planning: Each county is required to develop a biennial community social service plan through which it provides information to residents of the county about the services that will be available for the two year period. This plan must specify the methods of identifying needs and persons needing services, a description of services and agencies to be used, methods of insuring citizen participation in planning, an inventory of service available, evidence that purchase of services from the private sector has been considered and the goals of the local plan. The similarity to the plan requirements under Title XX is more than coincidental. A conscious effort was made in the development of the legislation to include requirements and provisions having enough similarity to Title XX so that the requirements of the state law would at least be compatible with, if not identical to, those of Title XX. Furthermore, timetables governing the plan are sufficiently similar to those for the Title XX proposed and final plans that the requirements of both can be met through the same planning process and plan documents.

The State Agency Role: Minnesota has a long history of commitment to the value of a state supervised, locally administered, public welfare program. This Act reinforces and clarifies the roles and responsibilities of both actors in the system. The supervisory duties of the state agency can be summarized as standard-setting, provision of technical assistance, county plan review and approval, distribution of funds according to the formulas, preparation of a state biennial plan for the Governor and the Legislature, evaluation of community social service programs, and annual publication of an evaluation report of community social service programs. There are fiscal penalties provided for in the law for certain acts of non-compliance on the part of counties. Certain of those are to be enforced by the state agency.

Issues: Some groups are concerned that the funding and providing of social services and mental health programs which have been supported on a statewide basis will be cut back. The counter argument is that service programs will be better tailored to the specific needs of local communities and that the planning requirements, including needs assessment and public participation in the development of the local plans, are safeguards that will prevent arbitrary decisions about service availability.

The passage of the Community Social Service Act was by no means precipitous. It was passed after three years of legislative consideration that included many hours of committee hearings, extensive debate, a multitude of amendments and finally reconciliation of considerable differences between the two chambers of the Legislature. It is an unequivocal expression of confidence in the state-supervised, locally administered system based on a belief that local elected officials are capable of making sound, humane decisions about the investment of local

government in meeting the human service needs of its citizens. Finally, it is a challenge to advocacy groups, elected officials, state and local agencies, members in the various human service professions and service providers to work together toward a common goal: the provision of humane, cost effective services at the local level.

MISSISSIPPI

**The Department of Public Welfare is the organizational unit at the State office level which supervises the provisions of all services to children and adults included in the State's social services plan. The Department carries responsibility for planning the content of the DPW service programs and establishing and interpreting service policies and procedures under the service provisions of Title XX, Title IV-B, and Title IV-C of the Social Security Act, relevant State statutes and the State's service plan. For all service programs, the Department provides supervision to assure that the implementation is meeting plan requirements and state policies and that funds are being used appropriately and effectively. Underlying the basic program planning and supervisory functions of the Department is a system of monitoring and evaluation of the service programs.

Regional staff consists of six Region Directors who are responsible for supervising the Region Assistance Supervisors, Region Service Supervisors and 84 county officers. The functions of the Region Supervisors include the following:

-- Serving as resource persons to county offices or the state office department. This may include any phase of the county program, including public relations and community development that is related to their program.
-- Providing assistance to the Program Department in policy development.
-- Participating in training activities as assigned.
-- Participating in activities to include reviews, evaluations or monitoring as assigned.
-- Providing technical assistance and supervision to county staff.

The county office is the administrative level at which individuals may apply for services provided directly through the Department or through a Purchase of Service contract. It is also the administrative level at which individuals will have their eligibility determined for these services. Staff in the county offices consists of the County Welfare Director, social services staff, pubic assistance staff, food assistance staff and other clerical and support staff. All staff in the county offices are directly responsible to the County Welfare Director, who in turn is responsible to the Region Director. County staff receives technical assistance, supervision, and support from Region Supervisors. Specific responsibilities of the County Welfare Departments in social services are as follows:

-- Efficient implementation of State welfare laws.
-- Compliance with written policies and procedures of the Agency.
-- Submitting reports of county activities.
-- Community leadership.
-- Resource development to help meet the needs of the community.
-- Developing plans and assuming responsibility for providing service when service is not available through other agencies.
-- Implementation of the Agency's social services program as set forth in written policy and procedure.

The Public Welfare Department also purchases social services so identified in the Comprehensive Annual Social Services Plan. The Agency has elected to purchase certain social services from public and private agencies through Purchase of Service (POS) contractual agreements. This agreement is a legal contract between the State Department of Public Welfare and a private or public agency, whereby the contracting party Agency agrees to finance and provide support to the service rendered by the contracting party. The contracting party will be restricted to the

services agreed upon and the budget approved for fulfilling the contract. Any deviation from the agreed upon contract must be made in accordance with policies set forth by the State Department of Public Welfare and approved by the Agency. The Agency is interested in developing and improving the provision of social services through Purchase of Service (POS) contractual agreements to meet the goals and objectives of the Agency as described in this Plan.

When a prospective contractor becomes interested in a POS contract he should first contact the Agency to explore the need for the proposed services. Together they explore the following areas:

-- Target Area.
-- Target Population.
-- Physical Facility to be used.
-- Matching Funds.
-- Charter of Incorporation or other authority to contract with the Agency.

If further negotiations are indicated the prospective contractor will be provided an application which, along with a prospectus of the program, will be submitted through channels to the Social Services Department. If approved at this stage, the contractor and appropriate staff will start final negotiations. Technical assistance as necessary is available from Social Services staff. Detailed information concerning the contracts, budgets and other procedures are in the Purchase of Service Handbook available at all county welfare offices. Amendments to, renewals or renegotiations of approved contracts are handled in the same manner as an original request.

When the DPW elects to purchase services, agency policy for POS contracts will be met and it will be determined that: required program standards will be met; services provided will be in line with the anticipated cost entailed; and the purchase of the service has been found to be appropriate and necessary.

Volunteer Services: In addition to the use of the above described administrative units, the Department of Public Welfare makes use of volunteers in the provision of services. Volunteers are individuals which are utilized for the purpose of complementing the work of paid staff and neither replace nor substitute for the work of paid staff except for specific instances in POS contracts. Volunteer services are performed by individuals or groups who serve voluntarily, contributing their time to the agency's services program.

Each county in the State has an approved Volunteer Plan which describes volunteer activities, their purpose and scope. Volunteer services in the county may be advisory, direct, or indirect in nature and are utilized according to the needs of clients and the organizational unit using them. Examples of volunteer services include serving on advisory committees, locating community resources, and providing transportation to those determined eligible.

**The Department of Health administers 82 county health departments and licenses all child-caring facilities. Very little purchase of service is done for community-based services and none specifically for children and youth. The department does have rape crisis subcontracts, some formerly in health education, and hypertension. However, most of the department's services are provided directly through the county health departments.

MISSOURI

**The Department of Social Services under the Division of Youth Services is responsible for youth committed by the Juvenile Courts in the state of Missouri. In years past, the Division was involved in a fair amount of purchase of service from community-based private not-for-profit providers; however, in the past several years, in view of numerous budget cuts, the division does very little purchase of service other than foster care and psychological, psychiatric, educational counseling and/or evaluation.

The Division of Youth Services serves youth between the ages of 12 and 17 years. The Division operates ten community-based group homes, four park camps, three high structure facilities ranging in population size from 30 to 60 youth; three residential short-term outdoor educational programs; and a Community Learning Center for specialized youth with developmental or special educational needs which cannot be met in the other facilities. Additionally, the Division operates a 20-bed reception unit, a Primary Care Program for youth who do not need institutionalization and an Aftercare Program (parole service) for youth upon release from the Division's facilities. The Division has a 368 bed budget capacity and at any given time approximately 425 youth on aftercare status. The Division's treatment program centers around a group therapy model.

MONTANA

No information was received.

NEBRASKA

**The Department of Social Services/Division of Children and Family Services supervises child welfare programs at the state level and at six field offices. Services are administered by the 93 county departments of social services. The State of Nebraska has a long history of contracting with private providers. The private providers offer a full range of services from intensive home-based family-centered programs to foster care, group homes, longer term residential services, diagnostic and evaluative services, and acute and longer range psychiatric programs.

The Division is currently working toward returning more children to their homes and maintaining more children in their homes of origin. This, of course, is consistent with federal and state guidelines and legislation. The Division is planning to create a workable document that would give instructions on how to return children who are currently placed out of state and to reunify those children currently placed in institutions throughout the State of Nebraska.

In order to facilitate this process, the agency has been utilizing the services of Gregory Lamm, MSW, ACSW, who has intensive experience in designing and implementing community-based services delivery systems for children as well as, most recently in Lincoln, Nebraska, the development of comprehensive alternatives to incarceration for nonviolent offenders. His activities will concentrate entirely on the service delivery system to children and families, and it is expected a comprehensive three-year plan will be developed by October 1, 1984.

The service delivery system design must involve leaders from throughout the State and must replicate a micro-community organization. To this end, a fairly standardized generic systemic orientation, with a functional base, has been utilized to facilitate this process.

NEVADA

**The Department of Human Resources provides adoption, protective services and substitute care for children and youth. Very little contracting of services is done.

NEW HAMPSHIRE

**The Department of Health and Welfare/Division of Welfare administers social services to children and youth. The Bureau of Child and Family Services is the lead agency responsible for adoption, protective services, and foster care programs. The division funds some community-based programs for children and youth in the area of child day care, family planning, homemaker, parent-aide, and parent-child support. The Division is primarily concerned with services which

provide alternatives to out-of-home placement. Through the Social Services Block Grant, services are developed according to community needs. Private, not-for-profit agencies submit a letter of intent, requesting funding for services authorized through the Division's Social Services Block Grant Plan. These letters are reviewed and, if approved, a contract is developed.

Some of these services are offered to all client populations, but if the purpose of the service is protection of children or prevention of placement, the services must be authorized by a Division Social Worker and the case must be active with the Division.

Other services are offered or arranged for community-based care for families and children, but are not funded through the Division of Welfare, via the contract method. For instance, if a family needs parenting classes, these may be funded through United Way, Mental Health, or the Division of Welfare. The Division does have a full referral component and is aware of services offered by other agencies.

NEW JERSEY

**The Department of Human Services/Division of Youth and Family Services administers services to children, youth, and their families. The Division operates through district offices in every county -- which are supervised by four regional offices. Fiscal year 1984 is to place an emphasis on community-based services and prevention. Presently, the Division is designing an approach to link family and community services.

The Division created several service principles as a framework for service delivery. Below are some of the principles that are still being discussed.

1. Unified Service System: This principle begins with a commitment to local based services, which are available and readily accessible. To achieve this, the service delivery system must be organized in a manner which assures public/private cooperation and coordination, and recognizes all levels of service provision, from informal and less restrictive to formal and more structured assistance.

   The principles of a unified service system suggests that the first level of response should occur within natural support systems (e.g., friends, self-help groups). This informal system must be supported and promoted as a first line of assistance. The second level of response is local community service providers (local government and private, nonprofit agencies), who should be the most geographically accessible and most familiar with local family and community problems. Finally, the third level of response should be the state-operated service sector. Services delivered by this sector must respond in a timely and affirmative manner when the needs of the individuals or families are critical and cannot be met by natural support systems or local service providers. This is particularly true in protective service cases.

   This three-tiered service system can be strengthened through coordinated planning among "partner" agencies and clear guidelines which assure adequate and timely initial response, case management, service availability and clear client pathways.

2. Advocacy: All participants in the service delivery, from clients (self-help groups) to service provider, to managers, must actively support a more responsive service system. For example, the case management system must be developed along a model which accentuates linkages to support services and brokerage on behalf of individuals, families, and communities in need.

   This principle underscores the rights, interests, and uniqueness of clients, and promotes the role of "capacity builders" for managers; that is, building the capacity for clients to make their contact with the social service system as less intense, infrequent, and short as possible.

Finally, the principle of advocacy requires a recognition that some individuals, families, and communities are more in need of assistance than others, due to the immediacy of a crisis or absence of family and community supports. These individuals, families, and communities require more aid, assistance, and attention, than families not in crisis or in situations where family and community supports are more readily available and accessible.

**The Department of Corrections under the Division of Juvenile Services, has very few contracts with private non-profit agencies even though the Division serves 1,000 youngsters. Most of the services are delivered through state-run programs, roughly 48% are in community or residential type facilities, 94% are in secure facilities and the remaining youngsters are assigned to training school facilities.

NEW MEXICO

**The 1983 Community Corrections Act authorizes the New Mexico Corrections Department to contract with counties, cities, nonprofit organizations, or combinations thereof to develop, establish and maintain Community Corrections services. This legislation will allow local governments and citizens to develop community corrections alternatives to incarceration. Programs funded pursuant to the legislation will divert adult offenders and adjudicated delinquents to community based settings and reintegrate adult offenders and adjudicated delinquents back into the community after incarceration in a correctional facility.

Community Corrections Programs will provide:

1. A range of residential and nonresidential diversion and reintegration programs for adult offenders and adjudicated delinquents with enough flexibility to meet the specific needs of each participant;

2. Support and assistance to diversion and reintegration program participants in developing self confidence and in learning to legally provide resources on their own; and

3. Diversion of adult offenders and adjudicated delinquents from further entry into the criminal justice system, and reintegration of adult offenders and adjudicated delinquents into self-sufficient and productive community living.

4. Services for other adults or children consistent with the goals and priorities of the Community Corrections Act.

The contractors (local public and private agencies receiving funds) have administered responsibilities in order to maintain funding.

1. It shall be the Contractor's responsibility to maintain documentation proving that provisions in the contract with the New Mexico Corrections Department are met.

2. Contractors shall have an up-to-date written manual which shall be available to, and reviewed by, the contractors' staff describing the purpose, philosophy, programs, services and policies of the program. The Contractor must operate according to this manual. The manual shall be available to the Community Corrections Act Administrator who may review and require changes as deemed appropriate.

3. Contractors shall attend and participate in meetings required by the Corrections Department.

4. The Contractor shall adopt regulations consistent with standards required by the Community Corrections Act Administrator.

5. Grants to contractors will be for no more than ninety-five percent of total program costs. No more than five percent of a grant may be used for administrative costs. The five percent of total program costs provided by the contractor (matching funds) may be used for administrative costs in addition to the five percent allotted in the grant and may be provided in in-kind administrative services. Administrative cost will be defined by the Corrections Department.

Funding recommendations are made by the Application Review Panel appointed by the Secretary of Corrections. The Department makes the final decisions.

NEW YORK

**The Department of Mental Hygiene/Office of Mental Health is in charge of the Unified Service System where a dual system of care (local government and the private/voluntary sector, on the one hand, and the state institutional system, on the other) move to an integrated system with its attendant unified administrative, fiscal, and programmatic responsibilities. Unified services offer the opportunity for a total integration of public mental hygiene services, including not only local components and voluntary nonprofit agencies, under the guiding and embracing arm of a community mental health department, but also the local outpatient components of state facilities.

The intent of the 1974 legislation was to encourage alternatives to state hospital admission and centralize coordinating responsibilities for planning within a community. Five counties became pilot projects, while other counties were waiting to see the results. Within one year after beginning operation, the new Governor's administration put a moratorium on further conversions of counties into the unified service system.

Unified services have provided the following benefits for the five New York counties that have adopted the system:

1. A mechanism for joint, integrated planning and program development.
2. A reduction of duplication, service gaps, and barriers to service.
3. A more effective and economical use of resources through shared staffing arrangements.

Fiscally speaking, unified services have also disappointed the state. While the counties using unified services cost the state less by using state facilities less, they also cost the state more since they earn a higher rate of state aid. This disadvantage to the state was expected to be offset by decreased state hospital admissions and costs, and while admissions have indeed dropped in five counties that adopted unified services, the state has not benefited to the extent anticipated. In fact, state hospital costs have continued to rise despite vast reductions in population, apparently because of a continued state commitment to the hospital work force and to each host community, which sees its state hospital as a major employer.

**The Division for Youth operates residential and day service programs for troubled youth, including counseling, education, and vocational instruction. The agency sponsors community-run programs for youth, recreation and delinquency prevention; provides technical and financial assistance to agencies involved in community youth programs and monitors activities of voluntary child-care and detention agencies.

The Runaway/Homeless Youth Program, Special Delinquency Prevention Program, and Youth Development/Delinquency Prevention are all community level ventures supported by state, county, and municipal funds, as well as private contributions.

Community level services started in 1945, when a Temporary State Youth Commission was created to provide technical and financial support to youth programs in communities throughout New York State. Programs were intended to provide services for the personal development of youth and to

prevent, detect and treat delinquency. Funding was provided to local governments based on a per capita formula of twenty-five cents per youth residing in the community. Local governments were required to provide matching funds. Over the years the per capita formula gradually increased until in 1974 the per capita formula had reached seventy-five cents per youth with double state aid ($1.50/youth) available in high delinquency areas.

This program of the State Youth Commission, which later became the Division for Youth, served as the basis of the State's involvement for thirty years. Under this program, the State provided a financial incentive for local governments to become involved in providing youth services. It allowed for services to be developed in response to locally identified needs.

Initially the primary focus was on developing recreation services. Slowly the focus expanded to include youth services and a local administrative arm called the Youth Bureau. Now over 2800 programs are operated by local community groups receiving some financial assistance from DFY to provide recreation and youth services. Youth Bureaus are now operated by 50 counties in the State. They have also been established in most of the larger cities and towns. Youth Bureaus provide coordination, planning, program monitoring and evaluation for all youth related activities in their community. Some Youth Bureaus, particularly those with smaller populations also directly operated some youth services.

In 1974 legislation was enacted which significantly affected this program. It eliminated double state aid for high delinquency areas but increased the basic per capita funding formula to a maximum of $4.50 per youth under two alternative methods. Under the first alternative municipalities could operate independently and receive an increase in per capita funding to $2.25 per youth. It established a new concept of "comprehensive youth services planning" on a county basis and provides a financial incentive ($4.50/youth) for counties to work with their cities, towns and villages in developing this common plan of action in addressing youth service needs. The intentions of introducing comprehensive youth services planning at the county level of government were:

1. to provide an incentive for cooperation among county, city and town governments and between private youth serving organizations.

2. to make more effective use of limited community resources.

A significant feature of the comprehensive planning process was it established a county-wide planning committee. The planning committee brings together a cross-section of the county's interests including representatives from city, town and village governments; minorities; women; youth; private businesses; and public and private youth service agencies. It offers opportunities for greater citizen involvement in the decision-making process and a forum for dialogue on youth needs and how they may be met. Through this committee the county identifies and documents youth service resources, unmet needs, and establishes priorities for youth services. The entire process tends to generate greater citizen awareness and interest in youth issues and needs and serves as a vehicle to formulate a common plan of action to meet youth needs.

**The Department of Health supervises statewide health programs and handles part of the funding. Approximately half of 57 counties have health departments; the remainder are served by the state Department, which maintains six regional offices. Counties with health departments receive about 45% of their funding from state and federal sources.

NORTH CAROLINA

**The Department of Human Resources supervises social and health services for children and youth which are administered locally by social services departments and health departments in the state's 100 counties. The Division of Youth Services works with 11 to 16 year-old youth. It has a community-based Alternatives Program for status offenders and youth who are at risk of either

being placed in a training school facility or entering into the juvenile justice system. The Division subsidized a county or a regional grouping of counties giving them the duty to disperse the funds to local private agencies. Recommendations for funding emanating from a local task force within each county are approved by the county boards of commissioners. These program agreements are then reviewed and approved by the Community-based Alternative central office.

The Task Force not only gives recommendations for funding, but also develops an annual comprehensive plan which includes a need assessment and funding priorities.

The Division of Youth grants $2,500 to each participating county plus funds that are pro-rated according to the number of 10 to 17 year-olds in the county. This program (community-based alternative) is a voluntary participation. As of 1983, all the counties in North Carolina are participating.

NORTH DAKOTA

**The Department of Human Services under the Children and Family Unit has a juvenile justice system which utilizes local private agencies. Also several other public and private agencies administer services for the juvenile such as the North Dakota Industrial School, the North Dakota Juvenile Courts through their juvenile court staff, private residential group care facilities such as Home on the Range for Boys, Dakota Boys Ranch, and Luther Hall, the North Dakota State Hospital, and public and privately operated group homes. All of these agencies maintain ongoing contact with one another as children move from one agency to the next. It should also be mentioned that 11 of the programs within Children and Family Services of the Department of Human Services are interdependent upon one another where programs such as foster care, and child abuse and neglect are closely related with community correction services.

The Community Correction Program provides a wide range of community-based, family-focused treatment and rehabilitation services to delinquent, pre-delinquent or unruly youth who are in conflict or potentially in conflict with the law in as normal a living environment as possible. Services are designed to prevent or correct delinquent behavior and divert youth from entering the juvenile or criminal justice system. Most of the correctional services are provided through the eight regional human service centers. They currently employ 13 part-time or full-time correctional representatives. These workers all have bachelor's or master's degrees in the human service field and have had experiences working with adolescents and family counseling. Services are provided directly and facilitated by these regional workers. Their direct services include counseling and therapy and information and referral. Indirect services include companionship, education, emergency services, sheltered care, family planning and placement. Indirect services are usually provided by other specialists within the human service center or agencies outside of the center. Traditionally these correction workers are case managers; certainly not able to provide all services to meet the needs of the youth.

OHIO

**The Department of Youth Services only serves youths (aged 12 to 18) adjudicated as felons or capital offenders. The Department operates nine facilities, including two minimum security centers, two maximum security institutes, and five medium security institutions. The Department has a policy of placing youth in the least restrictive setting possible, but close attention is given to a complete treatment plan, which includes aftercare supervision. Aftercare services include counseling, educational programs, and residential foster care.

For the less serious offenders, a youth service subsidy program is implemented on the county level. This subsidy distributes money to Ohio's 88 counties on an annual basis for non-secure programs. These non-secure programs are designed to provide services to delinquent and unruly youth at the local level.

The Department of Youth Services applies the following formula to determine the amount each county is to receive annually pursuant to this section, subject to the appropriation for this purpose to the Department made by the General Assembly:

(1) Each county shall receive a basic annual grant of fifty thousand dollars.
(2) The sum of the basic annual grants provided under division (B)(1) of this section than shall be subtracted from the total amount of funds appropriated to the Department of Youth Services for the purpose of the grants described in division (A) of this section to determine the remaining portion of the funds appropriated. The remaining portion of the funds appropriated then shall be distributed on a per capita basis to each county that has a population of more than twenty-five thousand for that portion of the population of the county that exceeds twenty-five thousand.

**The Department of Public Welfare supervises social services programs for children and youth. These services are administered either by county departments of public welfare or by children's services boards which operate in 41 of the 88 Ohio counties. (Ohio law allows counties to elect whether to provide children's services separately or combine them with welfare department services.) Funding for children's services is primarily a county function, assisted by federal allocations under Title XX and Title IV-B of the Social Security Act.

OKLAHOMA

**The Department of Human Services, due to 1982 legislation, administers institutional, social and rehabilitative services through a centralized system. Supervisory divisions and units are headquartered under the director. Program services are provided by the Department through offices in all 77 counties.

Under the Children's Services Unit, child abuse/neglect, foster care and adoptions, and child care facilities licensing is administered. The Children's Services Unit services some 4,100 deprived adjudicated children at any given time. 3,000 of these children are in the Department's custody and 1,100 are court ordered supervision cases.

Of the 4,100 children serviced, some 2,100 of these children reside in their own home or a relatives' home. Some 1,600 of the children reside in foster family care.

The Children's Services Unit operates five regional foster homes that service special needs children. There are thirty-five beds provided by these five homes. The caretakers receive a hundred dollar a month subsidy on a per child basis over and above the boarding home rate for care of these children.

The Children's Services Unit has access to placement in fifteen licensed residential care facilities statewide. Reimbursement is at the rate of $420 per month. These facilities generally service children with minor behavior difficulties who cannot function in traditional foster family care.

The Children's Services Unit maintains specialized contracts with three private facilities to provide residential care for children with a combination of behavior, emotional and educational problems, children who would have traditionally been serviced in an institutional setting. The Unit purchases fifty-eight beds from these providers at $52.93 per day on an as-used basis.

The Children's Services Unit has plans to put in place two more contracted group homes, one for adolescent females and one for early adolescent males.

The Children's Services Unit has a contract proposed with a private agency to provide therapeutic foster care for children coming out of residential psychiatric placement or as a diversion to residential psychiatric placement.

The Children's Services Unit is moving toward implementing a series of mini-group homes or professional foster homes. These homes will operate on a salary basis of $34,500 per year plus boarding home rate. Maximum capacity will be four children. These homes will be scattered state wide and can service a variety of special needs children on an intensive basis.

**The Department of Mental Health operates three psychiatric group homes in Oklahoma. The children can enter these upon placement into the custody of the Department of Mental Health.

There are some 150 Children's Services Unit children in the state run Developmentally Disabled and Mentally Retarded schools. The Schools are rapidly moving toward developing a continuum of community based care including group homes and mini-group homes.

**The Department of Health funds guidance centers which provide community health services. The Guidance Center is part of a network of multidisciplinary diagnostic, treatment, and primary prevention services operated under the auspices of the local County Health Department and the Oklahoma State Department of Health. Each Center's function is to provide outpatient services for children and their families.

Funded by local and state sources, the network of Guidance Centers is statewide and is accessible to all Oklahoma residents. Fees are charged on a sliding scale, but no one is refused service because of inability to pay.

Referrals to the Guidance Centers are made by schools, Head Start agencies, physicians, ministers, community agencies, and law enforcement personnel, or individual families may request services.

The local Guidance Center provides evaluations of children for psychological, developmental, speech, language, and hearing problems through: interviews; screening and standardized testing; and referral to appropriate agencies as needed.

Primary intervention--the prevention of problems--is provided through: parent study groups and workshops; parent/child enrichment programs; promotion of family strengths; normal growth and development information; and developmental assessments.

Group, individual, and family treatment are also available for: emotional, behavioral, and learning problems; family miscommunication and disharmony; speech, language, and hearing problems.

Finally, educational and consultation services are provided through cooperative efforts with: schools; Head Start; courts; other community agencies and organizations.

The Guidance Center system offers professional staff in six major areas; child development, psychology, social work, speech pathology, audiology, and recreational therapy. Clinicians hold graduate degrees in their specialties and are approved by the Oklahoma Merit System. Consultants are used in the areas of pediatrics, neurology, psychiatry, otolaryngology, and other specialties.

OREGON

**The Department of Human Resources/Children's Services Division administers five major categories of services--preventive and restorative care, protective services, adoption, substitute care and treatment, and juvenile correction--through six regional and 40 branch offices covering the entire state. Under the Division, community-based services are mainly purchased to serve delinquent youth.

PENNSYLVANIA

**The Department of Public Welfare's Office of Children, Youth and Families is the administrative arm of Pennsylvania's children and youth service system. DPW/OCYF has three essential functions:

1. Promulgating and enforcing all rules and regulations related to child welfare.
2. Licensing and inspecting all facilities used for the placement of children (i.e., group homes, shelters, detention centers, dependency and delinquency institutions--both public and private); and
3. Reimbursing counties for providing services for dependent and delinquent children (excludes services provided by the juvenile probation department).

DPW is responsible for the administration of Act 148, the largest existing children's state subsidy funded at $104 million for FY 82/83. DPW allocates these funds to county welfare departments through their county commissioners, who must submit an annual service plan to the department.

Pennsylvania's service system is state supervised and county administered. DPW is comprised of regional offices that supervise the county children and youth agencies having direct service delivery responsibility. Within each county children and youth agency exists a separate entity for providing services to abused children--a child protective services (CPS) unit. Through purchase-of-service contracts with the counties, other private and public service providers become an extension of the formal system.

To fully understand the functions of the Department; it would be best to explain the two new pieces of legislation that have affected the delivery of services.

Act 41, which amended the Pennsylvania Juvenile Act, provides a framework for examining the goals, structure, and components of the state's children and youth service delivery system.

The act has four basic goals:

1. To preserve the unity of the family whenever possible and to provide for the care, protection, and wholesome mental and physical development of children.
2. To remove from children who have committed delinquent acts the consequences of criminal behavior and to substitute a program of supervision, care, and rehabilitation.
3. To achieve the foregoing purposes in a family environment whenever possible, separating the child from parents only when necessary for his welfare or in the interest of public safety.
4. To provide a means through which the provisions of this act are executed and enforced and in which the parties are assured a fair hearing and have their constitutional and other legal rights recognized and enforced.

Thus, the thrust of Act 41 is to preserve the family by providing prevention, intervention, and treatment services.

Act 41 specifies only two classifications of children: delinquent and dependent. The dependent category encompasses a broad spectrum, including all status offenders.

Act 41 also governs the handling of juvenile offenders and nonoffenders and is unique in its specificity. The act prohibits detention of such children in adult jails and lockups. It stipulates which facilities may be used for detention of alleged delinquent or dependent youth. Act 41 laid the groundwork for the type of service delivery system to be established in Pennsylvania, i.e., a community-based service using the least restrictive setting for both delinquent and dependent children and youth.

Act 41 established the framework of Pennsylvania's juvenile justice and child welfare systems. Act 148, its counterpart, provides the state funding mechanism for the children and youth services delivery system.

The services delivery system in any state depends upon the dollars available to support it, the axiom of "services follow dollars." Prior to the passage of Act 148 in 1976, Pennsylvania's allocation and reimbursement process from the state to the county level encouraged institutionalization: the state paid 100 percent of the cost for every child institutionalized in a state-operated facility, while only 50 percent of the cost of county-level services was reimbursed. Act 148 reversed this trend by giving higher reimbursement for in-home and community-based services than for institutional services. This act is essentially an incentive funding plan designed to encourage each county to develop delinquency prevention programs, more and improved child welfare services, community-based services, and where necessary, residential alternatives to institutionalization. In general, if a service or program is community-based, the reimbursement rate to counties varies from 75 to 90 percent; if institutional in nature, the rate is 50 percent.

Another provision of Act 148 requires that, in addition to these standard service reimbursements, special state grants (block grants and additional grants) are to be available to assist counties in developing new services for children and youth.

This change in the allocation formula underscored a shift in public policy toward the values of home and community. As stated by the Department of Public Welfare: "The major intent of Act 148 is to move away from the unnecessary placement of children in traditional institutions by providing financial incentives to serve children in their own homes and in community-based services."

**The Department of Health operates a system of eight district offices and 61 local health centers to provide health services for children and youth. It also funds one bi-city and five county health departments along with school district health programs. The Department also contracts with private agencies to provide comprehensive health services to children and youth in the inner cities of Philadelphia and Pittsburgh. In addition, the Department, within its own community health district system of 170 sites for child health conferences, provides preventive health services to children 0 to 6 years old. Title V Maternal and Child Health Block Grant funds support these programs in great measure.

RHODE ISLAND

**The Department for Children and Their Families provides direct services through three regional offices that cover the entire state. These services include adoption, foster care, child protection, family counseling, residential treatment, and day care for emotionally disturbed children, youth corrections and probation and youth services. Under the Division of Community Services, the Division contracts with private vendors to provide a number of preventative programs or alternatives for children and youth. Three of the most significant are:

1. Comprehensive Emergency Services: A home-based services system providing emergency intake, homemakers, respite (foster) care, day care, counseling, and case management to avoid placement in abuse, neglect, or dependency cases.

2. Alternatives to Residential Treatment: An intensive home and community program that provides therapeutic intervention to emotionally disturbed children and youth awaiting or returning from residential treatment.

3. A network of small, residential, community-based programs providing a range of care and treatment services to children and youth.

SOUTH CAROLINA

**The Department of Youth Services provides a variety of services for juveniles. They are:

Prevention: In the area of promoting law related education programs in the elementary and middle schools, the Department established linkages with the South Carolina Bar Foundation, the Carolina Law Related Education Consortium, local school districts and the St. Paul Companies, Inc. The Department views the provision of prevention staff resources as appropriate funding contributions to locally initiated prevention efforts. Technical assistance is provided to organizations, schools, and citizens as they seek programmatic funding from public and private sources.

24 Hour Detention/Release Screening: The Division is responsible for determining whether youth taken into custody by law enforcement should be confined in jails or released pending court appearance. This is accomplished through the use of statewide contractual agents for evening, weekend, and holidays calls. Detention agents were paid through the use of Federal funds until 1983. State appropriated funding then became available.

Restitution: Legislation enacted in 1980 authorized the Family Court and the Juvenile Parole Board to impose restitution i the form of supervised community services or monetary reparation up to the amount of $500. Fire stations, animal shelters, churches, recreation departments, and law enforcement agencies are typical of the public and private non-profit organizations recruited as work sites for community service. The Juvenile Restitution Program in Charleston, a private organization, has provided technical assistance to the Department and coordinated efforts in that area.

Support Services: Included in this unit's services are residential and foster home care. The Department operates five group homes and shelters as well as a special intensive program for chronic status offenders. Thirteen private group homes throughout the state are also on contract for additional bedspaces. State appropriated funds are utilized for private group home contracts. Foster care is alternative placement for children who cannot remain or return from to their homes. Department certified foster care homes may be short or long-term depending upon the needs of the child. The Department also operates the Jail Removal Initiative Program which utilizes foster home families and residential care facilities willing to place children in lieu of jailing. Foster homes are paid through state funds. The Jail Removal Initiative Program uses federal funds.

**The Department of Mental Health generally does not provide funding for private agencies. There has been two pilot projects that examine the cost of putting a child in an alternative community setting instead of a state hospital. One of the projects was to secure funding from State Legislative tax funds to initiate "community treatment homes", a small, intensive treatment facility in a neighborhood home (located in a community accepted setting), associated with a local mental health center and public school special education programs. These homes are designed to be operated by a private non-profit corporation of community leaders associated with and supportive of community children's services, on contract from this agency's central office for community mental health centers. The Department has two such demonstration homes and is very pleased with their development and achievement. Central to their success are: local and state leadership collaboration, local autonomy to meet state standards, local community resources rather than institutional resources, full exploration and use of other private/public funding for a particular child. The programs do not qualify for Title 19 (Medicaid) funding for residential care, but do for treatment programs, medical expenses, etc. The Department's immediate goal is one community treatment home for each mental health center catchment area.

The second project which has been recently initiated is a "Continuum for Care" for seriously emotionally disturbed children. This novel approach is a three year demonstration project status and involves all child-serving agencies in the State.

SOUTH DAKOTA

**The Department of Social Services is administered by the Department's fifteen multi-county service areas which are supervised by four district offices. Child welfare programs include protective, foster care, adoption, day care and in-home services. There is a central registry for suspected cases of child maltreatment.

**Under the Department of Health, the community development disabilities service system is totally private and non-profit. These facilities provide services to both children and adults and are monitored by appropriate State agencies. For example, the Section for Special Education, Division of Elementary and Secondary Education, is involved in monitoring community agencies serving education-age handicapped youngsters (0-21 years of age). The Office of Developmental Disabilities, Department of Social Services, is the agency that is primarily responsible for the certification and monitoring of community private, non-profit developmental disabilities facilities. The State of South Dakota incorporates into its community facility standards the Standards for Services for Developmentally Disabled Individuals by the Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons.

Services from the community developmental disabilities facilities are purchased by State agencies on a daily-unit basis. Rates for the services are negotiated with the community agencies on a cost basis using historical cost figures and projected expenditures. The rate negotiations are held by the Office of Developmental Disabilities with participation from the Section for Special Education and the Department of Vocational Rehabilitation. Specific contracts are quite explicit in describing the service to be provided and the type of client to be served.

The life safety/sanitation aspects of the community developmental disabilities facilities are also monitored by the Office of Developmental Disabilities through a contractual arrangement with the Department of Health.

TENNESSEE

**The Department of Corrections, serving adjudicated delinquents, contracts with approximately thirty different agencies throughout the state. These programs are referred to as "contract agencies". By definition, they are residential treatment facilities that have been licensed to provide child care by the Licensing Division of the state Department of Human Services or Mental Health and Mental Retardation. The purpose of contracting for services is to provide diversity and alternative community residential treamtent programs not available within the Department of Corrections and to meet the various and distinctive treatment needs of individual children, i.e. drug, alcohol, maternity care and mental retardation. Also, the Department views these agencies as options to institutionalization.

Tennessee is divided into nine Correctional regions and one foster home counselor is located in each regional office. These counselors serve as liaison between the Department and the agencies contracted with. Prior to developing a contractual agreement with any licensed agency, the foster home counselor will gather information about the agency which includes a copy of their operating budget. Based on this information, a decision is made as to whether or not to contract for services. The Department then negotiates a monthly rate of reimbursement per child. Upon each child's placement, a contract is signed by both parties outlining expectations. The contract extends the duration of time a child is placed with an agency. Once a month, the agencies are responsible for completing Room and Board Certification slips verifying the number of days that month a child was in care. Reimbursement payments are authorized via this document.

TEXAS

**The Department of Community Affairs' mission is to help local governments improve services to citizens. The Department is working on projects to improve the quality of local early childhood programs and other programs affecting children and youth, including employment and drug abuse services. Local child welfare boards are serving a greater advocacy role, and the Department is promoting interagency cooperation in the provision of services.

In providing services, the Department's priorities for children and youth are:

1) advocate and provide an articulate focus for the needs of children and youth and disseminate information to the public regarding children's and youth's services;
2) determine the extent and availability of public and private resources and services to children and youth and their families;
3) coordinate the determination of the need for services to children and youth in this state by surveying and measuring their unmet developmental needs and make recommendations to all appropriate public and private agencies as needed;
4) provide for the development and demonstration of programs that will enhance development of children and youth;
5) establish and promote cooperation among private groups and governmental agencies to encourage and assist families in the provision of an environment for children and youth suitable to their full development, particularly at the community level.
6) arrange technical assistance and consultation for sources and potential sources of services to children and youth;
7) encourage the development of systems for the efficient and effective delivery of services to children and youth and their families rendered by the departments and agencies of state government including particularly services delivered at the neighborhood and community levels;
8) develop, revise, and implement a state plan for childhood development in cooperation with interagency councils and with the assistance of appropriate public and private groups and agencies providing for a mechanism at the community and state levels that assures a coordinated approach in assessing the need for and the delivery of services to children and youth and their families;
9) provide assistance, including financial assistance, in the administration of community multipurpose programs that assist children and youth and their families;
10) provide departmental assistance in developing and financing joint training programs for community-based staff specialists from the state and local agencies rendering services to children and youth and their families;
11) provide, perform, and promote consultative, evaluative, referral, and other functions as may be directed to improve service delivery;
12) provide services directly to children and youth and their families, but only to those who have needs which are not met from any other resources of state or community governments;
13) prepare and submit a report to the governor and appropriate interagency councils before September 1 prior to each legislative session containing a review of the status of services to children and youth, recommendations for priorities for the development and coordination of services to children and youth, and evaluation of the progress made as the result of the recommendations made in the past, a statement of goals for activities of the department relating to children and youth during the next year, and specific recommendations about what changes in law or appropriations need to be made to assist these programs to greater effectiveness.

**The Department of Health uses community-based services to provide maternal and child health programs. Child health clinics are established in most counties of the state and are staffed by local health departments or the public health regions of the Texas Department of Health. They focus on prevention and minor treatment to low income children from birth to five years of age but extending where needed through the school years.

The services provided include health history, physical examination, measurement of growth, and development, immunizations, laboratory tests and minor medical treatment, with referral and follow-up for hospital and other long term needs to cooperating public and private health resources at the local level.

Staffing of clinical programs varies considerably due to availability of personnel as well as sophistication of programs. In general, services are provided by physicians, public health nurses, nutritionists, social workers, clinic aides, and clerks.

Screening children of preschool and school age for vision, hearing and speech defects is carried out by schools and other community-based agencies. The role of the Texas Department of Health is to train, approve and certify screeners and trainers of this program. Those in need of further examination or treatment are referred to local resources. A state operated hearing aid loan program does provide hearing aids to eligible low income children.

A state mandated screening program for all newborns requires that infants be tested for phenylketonuria, galactosemia, congenital hypothyroidism, and sickle hemoglobin. Successful operation of this program entails the close cooperation of hospitals, private physicians, state laboratory, public health nurses, genetic centers, sickle cell agencies and state level staff of the Texas Department of Health.

In most of the above programs, there is no channeling of state funds to non-profit private agencies for the provision of services. Genetic centers and two sickle cell agencies have contracts with the Texas Department of Health for the provision of services in their field.

UTAH

**The Department of Social Services is making attempts to keep children out of foster care, group care and institutions. The approach has been to develop state plans, and based upon the state plans, issue RFP's (Request for Proposals) based upon funds available for private agencies to provide the services the state has identified. For example, the Department developed a state plan for serving the sexually abused child. The state legislature gave the Division funds for sexual abuse treatment. The Department determined the areas of need based upon the state plan and sent out RFP's to all private non-profit agencies. A committee was selected to award grants ranging from sexual abuse treatment to parents united groups, and community coordination networking. In fact, the entire budget, other than for state office personnel, is used for purchasing services.

VERMONT

**The Department of Health Services focuses on small children for early detection of developmental disabilities and on children with recognized birth defects. These services are offered through the Child Development Clinic which is a medical and public health program for children. The clinic offers evaluation and follow-up services, encouraging early identification and treatment for children with potential handicaps. Follow-up may include assistance with medical management, guidance in early care and developmental enrichment, referral to and coordination with other medical and community resources, assistance with educational planning, and parental counseling.

VIRGINIA

**The Department of Health is unique in that health services to the indigent and others are provided through a direct network of local health departments, all of which are a part of the State Department of Health and cooperatively funded by both state and local resources. Where specific

services are not available within the network of the State public health system these services are purchased from the private sector and other for profit and not-for-profit organizations and agencies.

Preventive health services are provided through all 127 local health jurisdictions in coordination and cooperation with the local providers in the area. It is this concept of networking that is utilized by the Department of Health in the Commonwealth of Virginia to assure that needed services are available, accessible and acceptable.

WASHINGTON

**The Department of Social and Health Services under the Division of Juvenile Rehabilitation, operates institutions and programs for the juvenile offender population, and is currently funding community-based programs at the local level through a Consolidated Juvenile Services Program. This program requires the coalescing of divergent points of view and a state and local partnership combining efforts and resources. The Division's role in this partnership is to provide leadership, structure and funds in promoting the program. The goals of the Consolidated Juvenile Services Program are:

1. Coordinate program strategies based on identified juvenile offender needs which promote just and equitable handling of the juvenile offender at the community level;

2. Develop comprehensive community plans for the delivery of services to juvenile offenders via broad-based professional/citizen input;

3. Encourage development of a unified system among state and local resources;

4. Foster the development of innovative and improved services for juvenile offenders;

5. Reduce reliance on state-operated juvenile correctional institutions; and

6. Set forth a clear administrative structure which ensures monitoring and evaluation of the delivery system.

A county or group of counties are asked to participate in the program by applying for funds. Other governmental units and private sector agencies may apply directly to the Division for project funds, but such application request must be reviewed by the review committee to ensure appropriate linkage to the county's juvenile justice system.

WEST VIRGINIA

**The Department of Health, under the Division of Developmentally Disabled, develop community alternatives instead of institutions. There is a specialized foster care for these children.

WISCONSIN

**The Department of Health and Social Services, Division of Community Services has direct administrative and funding relationships with local agencies, primarily its 72 counties. It also has relationships with community-based child caring institutions, group homes, etc. in addition to programs dealing with emotionally disturbed and developmentally disabled children.

The county agencies are responsible for actual service delivery. Services may be provided directly by county agency personnel or purchased from private agencies.

Each county agency, through a yearly coordinated Plan and Budget (CBB), establishes a plan for service delivery and determines the degree to which services will be provided by a county agency or purchased from community-based service providers. In other words, the method of service delivery is a matter of county choice in Wisconsin. However, approximately 20% of all funding provided to county agencies for family and children's services (exclusive of services provided specifically to elderly populations through local agencies on aging) are used to purchase services from private agencies. The types of family and children's services most often provided directly by the county agencies include: protective services to children; family counseling and related case management services; homemaker services; crisis intervention services; and juvenile justice supervision and related case management services. The types of family and children's services most often purchased by the county agencies include: day care; foster care; group care; residential treatment; intensive in-home/family treatment services; and, drug and alcohol treatment services. The purchased services are generally delivered by private community-based service agencies, residential treatment centers, and hospitals.

While the role of the Division of Community Services is primarily administrative, the Division does provide directly and contract directly for some family and children's services. Family and children's services provided directly by the Division include special needs adoption and adoption search services. Services for which the Division contracts directly with community-based agencies include domestic violence, runaway service and other adoption services.

A community-based program designed for juveniles entitled Family and Youth Aids Initiative is also housed under the Division of Community Services. This program serves juveniles aged 10 to 17 who are considered at-risk of being sent to correctional institutions. The recipient of Youth Aids monies is typically the county department of social services. The county acts as a broker of services for both institutional care and community care and establishes an advisory council (Youth Aids Planning Board) which develops the annual plan. The Department of Health and Social Services makes the final approval of the plan.

As a result of this program, there was a decrease in the total statewide expenditures for juvenile correctional care. The statewide expenditure for state-provided correctional services was decreased from approximately $16.5 million in 1980 to $12 million in 1982.

The numbers and types of community-based dispositional alternatives and related services developed through the Youth Aids Program varies considerably from county to county. Statewide data shows, however, that:

- Approximately seventy new social work positions were created statewide to provide intensive services to delinquents, status offenders and their families. Most of these positions provide individualized supervision services to youth;
- Twenty-four counties provide additional foster care services to juvenile offenders. Seventeen of these now include treatment foster care as a component of their foster care program, and six provide crisis foster care;
- Thirty-four counties provide intensive in-home and community treatment services in addition to traditional supervision services in order to reduce out-of-home and correctional placements;
- Seven counties provide day treatment services;
- Eighteen counties began or continued restitution programs for youth;
- Nine counties developed supervised work programs;
- Nine counties developed and expanded home detention services;
- Five counties provide independent living services;
- Eleven counties provide specialized volunteer services for youth;
- A wide variety of other programs also have been developed by the county departments of social services in response to specific community needs. These include recreational skill-building, diversion, cooperative police/social services, and school/social services.

Under the Division, the Community Options Program (COP), was implemented in 1982, and is designed to provide in-home support services to chronically disabled individuals, including children and youth, allowing them to be diverted from or released from institutions to community-based setting. While the primary emphasis in the COP program has been on adults, increasing attention is now being focused on removing children and youth from institutions. In addition, the Community Integration Program (CIP) was implemented and designed to to provide community-based support services to developmentally disabled individuals, allowing them to be removed from state institutes. The primary emphasis in the CIP program has been on children and youth, but resources may be used to deinstitutionalize adults as well.

There are two noteworthy family and children's preventive initiatives currently underway in Wisconsin. First, the state has set aside approximately $2 million of its federal IV-B/Child Welfare Allocation to fund projects designed to prevent out-of-home placements of children. Currently, fourteen county agencies are receiving grant funds for projects designed for that purpose. Second, the Positive Youth Development Program (PYD), a state-coordinated/volunteer-run primary prevention program is designed to address community problems and to reduce or eliminate conditions in the community which inhibit the healthy growth and development of children and youth.

**The Division of Health distributes Maternal and Child Health and Preventive Health and Health Services (PREVENTION) Block Grant Funds to approximately 130 local government and non-government agencies.

An extensive range of services are provided with Health Block Funding. Essentially there are two basic categories of programs: (1) preventive health care and (2) management of chronic and acute problems. A sizable portion of all the programs include an educational/information dissemination component. The following programs pertain to preventive health care: 1) blood pressure screening/education/follow-up, 2) communicable disease control, 3) dental health, 40 environmental health programs, 5) family planning, 6) genetics, 7) health promotion/education, 8) health screening/risks assessment, 9) infant metabolic screening, 10) nutrition education/assessment, 11) prenatal/post-partum/parenting skills, 12) primary health care, 13) refugee/migrant health, 14) sexual assault prevention, and 15) Sudden Infant Death Syndrome education. Management of chronic and acute problems programs include: 1) communicable disease control, 2) dental health, 3) emergency medical treatment, 4) environmental health programs, 5) genetics, 6) hemophilia, 7) home health care, 8) metabolic disease treatment, 9) primary health care, 10) refugee/migrant health, 11) sexual assault intervention services, 12) sickle cell anemia, and 13) Sudden Infant Death Syndrome response.

Although the majority of services appears to be provided by local public health agencies, it is important to note that local public health agencies frequently fund parts of numerous programs with block funds, whereas other (private non-profit) agencies tend to fund single whole programs (e.g. statewide Sudden Infant Death Syndrome program).

WYOMING

**The Department of Health and Social Services/Division of Community Programs is in charge of developing community networks in a number of areas across the state of Wyoming including mental health, substance abuse, developmental disabilities, sexual assault and family violence, and troubled youth programs. They use a small administrative staff to develop contracting procedures with private nonprofit groups across the state or on some occasions they will work directly with counties or county commissioners who have the responsibility for planning and determining how to best meet the particular program service needs in the local area. The Department has broken the state up into regional areas as small as seven (7) regions or as large as 23, or one (1) region for every county within the state. The size of the region will depend on the purpose of the program and the way that it is determined that services might best provide to Wyoming citizens. The following process takes place:

Letters of intent from particular areas are filed with the office and an application or plan is solicited. This spells out the program's capability of meeting the needs of the regional area. The commitment of local support in addition to state contract dollars or support from any other sources is requested.

If there are competing applications from the region, then the Division rules are to be utilized to make a consistent decision as to who should receive the local contract.

A contractor who has provided services in the past in an acceptable fashion will be reissued the contract. However, the Division has examples of contracts moved due to the demonstration at the local level in a lack of support or greater support for another entity to provide the particular services. The Division then funds on a contract basis the particular services and monitors the quality and quantity of services provided in accordance with standards established in each program area.

Although there have been problems, on balance, the Division receives a great deal of support in part because local areas feel that they have a degree of control and ability to tailor their program somewhat more flexibly than with line/staff agencies services delivery. The essential elements are 1) the ability to train and hold accountable local boards of directors, 2) monitor effectively, and 3) specify standards with which minimum services can be provided.

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BIBLIOGRAPHY

ALABAMA —

"Alabama Directory of Mental Retardation and Developmental Disabilities Service Programs," Department of Mental Health, 1983-84
"Developmental Disabilities Three Year State Plan," State Planning Council, State Administrating Agency for Developmental Disabilities, 1983

ARIZONA —

"Taxonomy of Services," Department of Economic Security, 1983

ARKANSAS —

"Division of Youth Services Orientation Presentation for Community-Based Agency Boards," Division of Youth Services, 1983

CALIFORNIA —

Barter, James T., "California - Transformation of Mental Health Care: 1957-1982," Unified Mental Health Systems: Utopia Unrealized, 1983
California, "Assembly Bill No. 607," Chapter 1082, 1983
California, "Senate Bill No. 789," Chapter 288, 1983
"County Justice System Subvention Program, Progress Report to the Legislature Number Three," Department of Youth Authority, 1981
James, J. Frank, "California's Transformation: Can We Learn from the Pioneer?," Unified Mental Health Systems: Utopia Unrealized, 1983
Phelan, Joseph, "California's County Justice System Subvention Program," Youth Authority Quarterly

COLORADO —

"Juvenile Diversion: From Politics to Policy," Division of Youth Services, 1983

CONNECTICUT —

"Five Year Master Rolling Plan," Division of Children and Youth Services, 1983-1988

FLORIDA —

Chackerian, Richard, Ph.D.; Frumkin, Michael, Ph.D.; Imershein, Allen, Ph.D.; Martin, Patricia, Ph.D., "Evaluating State Level Integration of Human Services," Administration in Social Work, 1983
"Child Welfare Services in Florida," Department of Health and Rehabilitative Services, 1983
"Deinstitutionalization of Florida's Children and Adolescents," Department of Health and Rehabilitative Services, 1982

GEORGIA —

Gay, R. Derril, "The Georgia Experience: Another Perspective," Unified Mental Health Systems: Utopia Unrealized, 1983
Miles, Donald G., "The Georgia Experience: Unifying State and Local Services Around the Balanced Service System Model," Unified Mental Health Systems: Utopia Unrealized, 1983

HAWAII —

"An Interview with Dr. Denis Mee-Lee, Chief, Mental Health Division," Hawaii Health Messenger, 1978

INDIANA —

Indiana, "Burns Indiana Statutes," 1983 Cumulative Supplement, Code Edition

IOWA —

"Description of Intended Expenditures and Statements of Assurances," Maternal and Child Health Services and Crippled Children's Services, 1983
"Maternal and Child Health/Dental, Administrative Manual," State Department of Health, 1983

MAINE —

"Purchase of Service Policy Manual," Department of Human Services, Bureau of Social Services, 1983
"Title XX - Social Services Block Grant Program Plan Report for FY October 1, 1983- September 30, 1984," Department of Human Services, 1983
"State Child Welfare Services Plan," Department of Human Services, 1983

MARYLAND —

"A Directory of Drug Abuse Treatment Programs and Organizations Offering Specific Services to Drug Abusers," Drug Abuse Administration, 1983

MASSACHUSETTS —

"Division of Family Health Services Handbook," Department of Public Health, 1981
Okin, Robert L., "A Proposal to Replace State Hospitals in Massachusetts," Unified Mental Health Systems: Utopia Unrealized, 1983

MICHIGAN —

"Child and Youth Services, FY 1981-1982," Department of Social Services, Office of Children and Youth Services, 1983
"Community Residential Care, An Introduction to the CRC Services Program in Michigan," Department of Social Services, Office of Children and Youth Services, 1981
"Services Manual Bulletin," Department of Social Services, 1982

MISSISSIPPI —

"Final Comprehensive Annual Social Services Plan," State Department of Public Welfare, 1983

NEBRASKA —

"Nebraska Juvenile Resource Directory," Department of Public Institutions

NEVADA —

Nevada, "State Welfare Division Service Manual," Section 417 - Protective Services for Children, 1983
Nevada, "State Welfare Division Service Manual," Section 419 - Substitute Care for Children, 1982

NEW JERSEY —

"Family and Community Services Plan, FY 1984," Department of Human Services, Division of Youth and Family Services, 1983

NEW YORK —

"Guidelines and Information for Comprehensive Youth Services Planning," Division for Youth, 1977
Moritz, Timothy B., "Discussion of New York's Unified Services," Unified Mental Health Systems: Utopia Unrealized, 1983
Pepper, Bert, Ryglewicz, Hilary, "Unified Services: A New York State Perspective," Unified Mental Health Systems: Utopia Unrealized, 1983
"Youth Development - Delinquency Prevention Programs," Division for Youth

NORTH CAROLINA —

"CBA Task Force Manual," Division of Youth Services, 1983
"Community-Based Alternatives Section," Division of Youth Services
North Carolina, "House Bill 456," Chapter 929, 1975
"Opening Doors for Children," A Study of the NC Community-Based Alternatives Program, Governor's Advisory Council on Children and Youth, 1983
"What They Need is Love," Annual Report on Community-Based Alternatives in North Carolina, Division of Youth Services, 1983

NORTH DAKOTA —

"Inter-Agency Agreement for Juvenile Correction Services," Department of Institutions, Department of Human Services, 1983
North Dakota, "State Youth Authority," Chapter 27-21
Sharff, Bill, "Community Corrections and the North Dakota State Youth Authority," Community Corrections and Interstate Compact

OKLAHOMA —

Oklahoma, "House Bill No. 1468," 1982

OREGON —

"CSD's Proposal: New Directions for Oregon's Juvenile Corrections System," Department of Human Resources, Children's Services Division, 1983
"Request for Proposal, (RFP) 3-3-2," Children's Services Division, 1983

PENNSYLVANIA —

Presley, Senator Robert, "A Legislator's View of Children and Youth Services," Legislator's Guide to Youth Services, 1982

TENNESSEE —

"Descriptive Catalogue, Child Caring Agencies in Tennessee," Department of Correction, 1982

TEXAS —

Iscoe, Louise, "E.C.I.: It's Making a Difference," Impact, March/April 1983
Iscoe, Louise, "Early Childhood Intervention," Zero to Three, December 1982
Texas, "Human Resources Code," Sections 1.001 to End, 1982
Texas, "Senate Bill No. 630," Chapter 572
"Title IV-B State Plan, 1984-86," Department of Human Resources

VERMONT --

"Handicapped Children's Services," Department of Health

WASHINGTON --

"Consolidated Juvenile Services Program Standards," Department of Social and Health Services, November, 1983
"Funding Methodology and Delivery of Services at the Local Level," Division of Juvenile Rehabilitation, January 1980
"Statement of Philosophy and Policy Objectives - CJS," Department of Social and Health Services, March 1982
Washington, "Substitute House Bill 433," 1983
"West's Revised Code of Washington Annotated," Chapter 43.121

WISCONSIN --

"Application Package," Division of Health, 1982
"Choice for Communities, Alternatives for Youth," Department of Health and Social Services, Division of Community Services, 1982
"CIP Update," Department of Health and Social Services, August 1983
Ganser, Leonard J., Stein, Leonard I., "Wisconsin's System for Funding Mental Health Services," Unified Mental Health System: Utopia Unrealized, 1983
"Health Block Grant Funds to Local Agencies," Department of Health and Social Services, 1983
"Questions and Answers About...DCS-Community Human Services Systems," Department of Health and Social Services, Division of Community Services, 1981
"Response to Requests for Shared Information on COP," Division of Community Services, 1983
"Understanding the Community Options Program in Wisconsin," Division of Community Services, 1983
"Wisconsin Community Options Program," FOCUS ON---, Division of Community Services, February 1983

WYOMING --

"Rules of Procedure for Division of Community Programs," Department of Health and Social Services, November 1983

"Child Protection Report's National Directory of Children and Youth Services, '83-'84," CPR Directory Services Co., Washington D.C. 20036

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